

**The case of “Molar City”, Mexico:
An ethical examination of medical tourism industry
practices**

**by
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Abstract

“Molar city” or Los Algodones, Mexico is characteristic of other medical border towns whose proximity to the Mexico-United States border enables American and Canadian patients to access desired health care. Patients can take advantage of economic asymmetries on either side of the border to purchase desired health care in an easily accessible location. Los Algodones is an exceptional industry site in northern Mexico, however, due to its focus on the provision of dental care and claims by local residents that it has the highest concentration of dentists per capita in the world. In this dissertation, I use a case study of Los Algodones’ dental tourism industry to provide an examination of ethical concerns for medical tourism industry practices. Drawing on findings from qualitative research exploring the perspectives and experiences of diverse industry stakeholders, this study contributes insight into ethical examinations for medical tourism informed by structural exploitation and structural injustice frameworks. By employing these ethical frameworks to examine one particular industry site, this research outlines how structural factors such as competition in the global industry and economic asymmetries between the global north and global south inform unfair localized industry practices. I highlight in this dissertation how industry practices are taken up by various industry stakeholders to maintain the flow of dental tourists to Los Algodones; however, efforts to promote and protect the success of the industry according to the interests of elite industry stakeholders inform practices characterized by the irresponsible use of health resources and degrading interactions. Overall, this research suggests that medical tourism industry development raises health equity concerns for the industry if exploitative practices in different industry sites produce poor labour conditions and access to care barriers for marginalized populations. Further research is needed to explore the utility of these ethical frameworks when examining other industry sites and possible policy implications for mitigating exploitative practices within different contexts of industry development.

Keywords: medical tourism; dental tourism; health equity; structural exploitation; global health

Dedication

To Karina and your family.

I hope you can be reunited on the same side of the border once again.

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Chapter 1.

Introduction

“Red solo cup, I’ll fill you up, let’s have a party, let’s have a party”... These lyrics blared through the speakers of one of many restaurants I passed throughout the day during my three months of fieldwork in the small town of Los Algodones, Mexico. I had conducted research in Los Algodones to learn more about the dental tourism industry operating in this small town. While other border towns in northern Mexico similarly sell dental care and other types of medical care to foreign tourists as part of a thriving medical tourism industry in in this region, industry stakeholders boast that Los Algodones is unique in its concentration of dental clinics catering to foreign tourists, making it the dental tourism capital of the world according to many local residents. Many residents I interviewed during my research hoped for the continued growth of the industry and suggested that the dental tourism industry is the most important economic sector in the region as numerous businesses rely on the daily flow of dental tourists into the town. However, as I sat at restaurants catering to recovering dental patients and accompanying friends and family members passing the time drinking margaritas and singing along to familiar tunes, I questioned whether everyone is truly enjoying the “party”. This questioning was informed by the perspectives of individuals living and working in Los Algodones and, over time, these perspectives began to shape the way I understood the industry in this site. Drawing on my experiences in Los Algodones, this dissertation provides an ethical examination of the medical tourism industry through a case study of industry practices in Los Algodones.



Figure 1. American and Canadian tourists enjoying a party to welcome tourists to Los Algodones

Photo credit: Krystyna Adams, 2015.

As I discuss further in this dissertation, my research highlights how, even though the medical tourism industry in this site provides important economic benefits to local residents and more affordable health care for many patients, these benefits are not necessarily sufficient to ensure the wellbeing of everyone in the population, and, in fact, the realization of these benefits might rely on the perpetuation of structural injustices. This research demonstrates how medical tourism practices follow closely the contours of global relations of power, exacerbating social determinants of ill health such as poverty, poor working conditions, and poor access to health care for vulnerable and marginalized populations globally. By tracing how structural factors are shaping localized industry practices, this case study highlights particular social conditions, institutional processes, and other structural factors which might produce similar injustices in other medical tourism industry sites, nuancing ethical examinations of the industry.

In the remainder of this introductory chapter, I situate my research within the field of global health and explain how this field of study informs my dissertation research and why I chose to examine industry practices within the industry site of Los Algodones, Mexico. After describing current discussions in the medical tourism literature related to

ethical concerns around medical tourism activities, I outline my research objectives as they relate to these theoretical discussions and provide an overview of the individual analyses that make up this dissertation.

1.1. Situating my research: Global health as a field of study

Broadly, global health research aims to inform global health practices. These practices work to improve the health of the global population while reducing health inequities between different countries, defined here as differences in health outcomes that are deemed unfair (Kang et al., 2015; Koplan et al., 2009; Smith, 2012). This aim distinguishes global health from public health research with the latter focusing more so on the health of the population of a specific country or community. Global health research instead examines threats to the health of populations which are global in nature (Beaglehole & Bonita, 2010). With this in mind, global health researchers often examine the role of global macrostructures such as global economic and social policies in shaping the health of localized populations and disparities in health between populations (Schrecker, 2016). Furthermore, this field of study has provided important insight into key concerns for global health practices informed by differing interests and values of global health actors, constraints to global health governance structures, and challenges to effective cooperation between states to promote more equitable health outcomes in the global population (Mackey & Liang, 2013).

While increasingly recognized as a disciplinary field in its own right, global health as a topic of inquiry suggests a critical departure from past efforts to address health issues through cooperative activities between international actors (Beaglehole & Bonita, 2010). Historians have traced the evolution of global health research by highlighting specific eras of this field with each era informed by the involvement of different actors with different interests and ideas of what counts as “good” global health practice. A key distinction is typically made in the literature between the era of international health characterized by efforts to improve the health of colonies to promote profitable activities for imperial powers and the era of global health. The global health era is typically characterized by cooperative efforts to address global health threats including efforts from actors beyond just governmental or intergovernmental organizations (Birn, 2009; Labonté et al., 2011). Most scholars agree that the field of international health was born out of activities and events in the mid-1800’s that established an institutional framework

for ongoing cooperation between nation states to address international health issues. These activities included the international sanitary conferences and the establishment of a commitment from participating countries to continue meeting and sharing scientific information (Birn, 2009). Some scholars argue that the field of international health originated as early as the 14th century when nation states first cooperated to deal with an emergent health issue, namely the bubonic plague (Banta, 2001); however, this early cooperation does not align with international health activities beginning in the 19th century which focused on improving health as a means of enhancing capitalist accumulation and not as an end in and of itself (Birn, 2009; Brown et al., 2006).

Activities conducted as part of the era of international health have garnered significant criticism from interdisciplinary academics for their role in extending and even exacerbating global health inequities where these activities supported or enabled structural injustices via imperialism (Labonté et al., 2011). In the post-colonial and post-World War Two era of international cooperation, new governance structures emerged, particularly the World Health Organization (WHO), significantly shifting the actors and ideas involved in global health practice away from the dark history of international health. However, criticisms of international health activities remain relevant to current global health practices and the failures of these practices to effectively address large disparities in health outcomes between the global north and global south (Birn, 2009; Brown et al., 2006). Here, I define the global south as the region of the world with a shared history of colonialism and neo imperialism and experiencing ongoing political and cultural marginalization through which inequalities in access to resources are maintained. I use the global north-south distinction throughout this dissertation to discuss structural factors informing global health inequities as this distinction emphasizes the geopolitical relations of power informing vastly different health outcomes between these two regions (Dados & Connell, 2012). The global north-south divide is a useful concept to explain various macro structural social determinants of health, including differential participation and power to affect global governance structures, whereas terms such as developed/underdeveloped distinguish between countries primarily based on income (Rubei et al., 2016).

With this definition in mind, critical examinations of global health practices have raised concerns about how activities and research agendas in global health are often developed by actors in the global north to address health issues “over there” resulting in

practices which do not necessarily address the most key factors informing ill-health, particularly when these factors necessitate restructuring of global governance structures and global relations of power (Banta, 2001; Koplan et al., 2009). These concerns emphasize the limited participation and representation from the most vulnerable and marginalized populations in global institutions and governance structures informing many global health practices. Without this participation, global health practices do not necessarily take into consideration the macro structures largely responsible for social determinants of ill-health in the global south including poverty, poorly resourced health care systems, and exploitative industry development, particularly as these activities serve the interests of elite actors throughout the global north and global south (Horton & Barker, 2010).

Global health scholars have demonstrated how globalization serves both to enhance cooperation towards addressing global health threats while also informing global relations of power in ways that challenge effective efforts to promote improved and more equitable health in the global population. This challenge is particularly relevant where the inclusion of new actors (i.e., corporate philanthropists) shift the values of global health practice away from a focus on promoting global health equity. For example, values oriented around measurable outcomes to appease donors financing global health activities might emphasize interventions with large health gains even if these gains are not experienced by populations with the most pressing health needs. Additionally, these interventions are often oriented around programs with quantifiable benefits that can be easily tracked instead of changes to large structural factors informing the social determinants of health (Brown et al., 2006; Ormond, 2013).

Good access to quality health care is considered one of the most direct social determinants of health (Beaglehole & Bonita, 2010). Health services research within the field of global health examines how global or macro structures such as global economic systems, global governance structures, and global geopolitical relations inform localized health care provision (Cohen, 2013). This research has emphasized how the movement of resources, people, and ideas across borders has challenged our understanding of the of the nation state in providing health care necessary to uphold the right to health for its citizens (Labonté et al., 2011). In response to this challenge, global health services practice has been characterized by cooperative efforts to meet the health care needs of populations regardless of nationality (i.e., humanitarian aid) (Koplan et al., 2009).

However, researchers have also raised social justice concerns for global health services if these services fail to conform to the values of health equity and health as a human right (Schrecker, 2016). Research on global health practice has emphasized how, according to global relations of power, this practice might actually exacerbate global health inequities. For example, these practices might follow closely the contours of global relations of power as donor stipulations encourage care practices which primarily serve their interests instead of the needs of the most marginalized populations. Furthermore, the provision of health care by international organizations with particular interests and values might result in the exclusion of certain populations from accessing needed care while disrupting national health system planning and equity-enhancing efforts (Berry, 2014; Labonté et al., 2011).

Finally, global health researchers have increasingly examined how neoliberalism informs health inequities. The circulation of neoliberal ideology exacerbates global health inequities by extending and entrenching social determinants of ill-health via reduced social welfare programs, the privatization and commodification of health care, and inequitable distribution of resources needed for wellbeing (Schrecker, 2016). Research on global health services practice critiques the implementation of neoliberal policies and programs (i.e. Structural Adjustment Programs) as they have informed and enabled the provision of health care according to profitability instead of need (Labonté et al., 2011). My dissertation directly contributes to this stream of global health research by examining how care provided within the medical tourism industry interacts with the social determinants of ill-health experienced by vulnerable and marginalized populations. I believe the research presented in this dissertation contributes new considerations to theoretical discussions regarding ideas, interests, and ideologies shaping global health services practice and responsibilities for promoting and securing equitable and just health care provision beyond national borders (Cohen, 2013; Collins-Drogul, 2006; Meghani, 2011)

1.2. Medical Tourism

1.2.1. What is medical tourism?

Global health researchers have increasingly examined mobilities such as medical tourism (Whittaker & Heng Leng, 2016), health worker migration (Hennebry et al., 2016),

and medical voluntourism (the movement of care providers across national borders to provide voluntary medical care) (Berry, 2014) to gain insight into the ways in which flows of patients and providers impact efforts to enhance health equity, both via the health care system and other social processes (i.e., the political economic and social-ecological systems) (Krieger, 2001). The term medical tourism is commonly used to refer to practices of individuals intentionally pursuing medical care outside their home country and paying out-of-pocket for this care (Lunt & Carrera, 2010). This term does not refer to medical services provided to foreign patients as a result of cross-border care arrangements or emergency medical treatment provided to individuals when traveling (Johnston et al., 2010). While historical reports of individuals traveling for medical care suggest this is not a new practice, increasing discussion in media reports and academic literature about medical tourism are driven by the growth of the global medical tourism industry (Crush & Chikanda, 2015; Ormond, 2011). This industry is characterized by the provision of private medical care to foreign patients (here referred to as medical tourists) (Smith, 2012). Patients might be motivated to travel to access more affordable care than typically available back home (especially for patients traveling from the global north to global south due to global economic asymmetries); for care that is more readily available without wait lists; and for care that might not be available at all in medical tourists' home countries due to health system regulations and standards of care (Johnston et al., 2010). Research indicates that medical tourists travel to purchase various types of treatment with common procedures cited in the literature including dental care (Miller-Thayer, 2010); cosmetic treatment (Turner, 2012); bariatric surgery (Snyder et al., 2016b); cardiovascular procedures and experimental care (Cohen, 2013).

Researchers have increasingly examined the topic of medical tourism due to expanding medical tourism infrastructure, increasing government interest in pursuing medical tourism activities, and increasing accounts of medical tourists' experiences accessing care abroad, all of which raise considerations for the health system impacts of medical tourism (Glinos et al., 2010). The majority of academic and media attention on medical tourism has focused on the flow of medical tourists from the global north to global south, as I explain in further detail below. However, academics have pointed out that there is also a significant south-south flow of patients informing the development of this global industry (Crush & Chikanda, 2015; Ormond, 2011). In certain contexts, this south-south flow of patients has prompted academics to argue in favour of more specific

terminology which better captures the realities of patients' decision-making (i.e., medical refugees in contexts of patients traveling out of low-resource health care systems) (Kangas, 2010). Furthermore, some academics prefer to employ the term "international medical travel" to avoid using the word "tourism" and equating this practice with other leisure activities (Kangas, 2007; Ormond, 2011; Turner, 2013). While the use of distinct terminology provides valuable insight into the different contexts in which individuals travel abroad for care, in this dissertation I employ the term medical tourism as I engage with critiques regarding the development of the global medical tourism industry, described in further detail below.

Medical tourism industry development has garnered significant academic attention to examine if and how this industry informs the privatization of health care globally, and the resulting health equity implications (Chen & Flood, 2013; Mainil et al., 2012). These discussions have raised concerns about the inclusion of new actors with divergent values and interests in the medical tourism industry. For example, industry development has implicated subsidiary companies and private businesses such as medical tourism facilitators who arrange the travel details for medical tourists, certification companies like the Joint Commission International (JCI), and the Medical Tourism Association (MTA), a non-profit trade association providing brand-development programs to a variety of industry stakeholders, all of whom might support industry development to enhance their businesses (<http://www.medicaltourismassociation.com>). Much of the academic attention has focused on the growth of the medical tourism industry in the global south where this development has proved particularly contentious: industry development has been described in the media and industry sources of information as driving economic development, particularly for developing countries reliant on foreign investment and tourism activities for this development (Sobo et al., 2010); however, research indicates that this development might negatively impact health care systems in destination countries while predominantly enhancing access to health care for patients from the global north (Chen & Flood, 2013; Martínez Álvarez & Chanda, 2011; Ormond, 2011; Smith, 2012). I expand on the ethical concerns specific to the north-south flow of medical tourism in the next section after introducing ethical concerns for medical tourism broadly.

1.2.2. Ethical Concerns for Medical Tourism

A large number of researchers across multiple disciplinary backgrounds have developed critical analyses of medical tourism activities (Cohen, 2012; Lunt & Carrera, 2010; Turner, 2007). Discussions of ethical concerns around medical tourism in the global health literature primarily focus on the potential negative impacts of these practices on efforts to promote health equity both in destination and departure countries (Martínez Álvarez & Chanda, 2011; Smith, 2012). For example, medical tourism might disrupt equitable access to health care if the development of new medical facilities catering to medical tourists shift health resources from the public to private sector (Connell, 2011). This shift is particularly concerning if finite health resources are used to provide more specialized or curative care, disrupting preventive care efforts that address health issues for the population, including patients unable to pay for specialized care (Snyder et al., 2013). Furthermore, research has demonstrated that public funds might be diverted away from care provision to facilitate industry development when paying for JCI certification of facilities catering to medical tourists and marketing and promoting the industry to potential customers (Pocock & Hong Phua, 2011).

Researchers have also highlighted how increased participation in medical tourism might also impact on the health care systems of sending countries, or countries from which medical tourists travel. Researchers have demonstrated how competition for patients in the global medical tourism industry has discouraged regulatory oversight of industry practices to reduce costs and attract patients based on lower prices than are available in other industry sites (Crooks et al., 2013). Operating within reduced regulatory frameworks, medical tourism activities might also exacerbate health inequities in medical tourists' home countries if health resources are used to treat harms caused by medical tourism procedures, potentially diverting finite health resources away from other patients in need of care and unable to travel as medical tourists (Turner, 2007). Potential harms commonly cited in the literature result from poorly regulated care provision and/or inadequate follow-up care if medical tourists travel home too quickly after their care and without sufficient medical records (Johnston et al., 2011; Turner, 2010). Care providers in medical tourists' home countries might also refuse to provide follow-up care or treat complications if they do not have the necessary records or information about previous treatment, potentially complicating treatment in ways that exacerbate patient safety risks (Adams et al., 2017).

While these concerns warrant careful ethical examination, here I focus on examining global health equity issues arising in the context of medical tourism industry development in the global south and catering to medical tourists from the global north. Academic discussions have suggested that industry development in this context provides “foreign safety nets” or “escape valves” for patients who can pay out-of-pocket for care in the medical tourism industry as a result of economic asymmetries between sending and destination countries (Cortez, 2013; Horton & Cole, 2011). In particular, academic discussions have raised global health equity concerns about industry development in this context if public funds in countries with high levels of unmet health care needs (i.e., India; Mexico) are used to subsidize care provision to foreign patients from more highly resourced countries (Sengupta, 2011). Research has demonstrated how, in certain contexts, public funds have been invested in medical tourism industry development as a form of tourism diversification with limited oversight or attention from government officials as to how many local patients will be treated as a result of this investment (Johnston et al., 2016; Ormond, 2013).

Medical tourism industry stakeholders have responded to health equity concerns around industry practices by highlighting the economic opportunities generated by the industry, suggesting the economic gains from the industry can be invested back into the public health care system and offset any negative impacts (Ormond, 2013; Snyder et al., 2015). Academics have questioned whether these economic gains are actually realized in various industry sites and whether substantial industry profits are invested into the public health care system to serve the populations most in need of health care (Imison & Schweinsberg, 2013; Sengupta, 2011). Research conducted by Johnston et al. (2016) indicates that governments in the Caribbean have dedicated time and resources to attract foreign investors while some governments in the region have paid for policy recommendations from the MTA. These efforts have raised concerns about the role of the MTA and other actors with a vested interest in the profitability of the industry if they promote industry development to financially support their organization with limited consideration for the on-the-ground realities for industry stakeholders in this competitive global industry. These concerns are particularly relevant in contexts where the MTA promotes industry development to countries in the global south whose economies are highly dependent on tourism as these countries are likely competing for the same pool of prospective medical tourists. This competition might not only limit the number of medical

tourists who actually travel to each of these countries, despite public investment in industry development, but it might also produce a race-to-the-bottom effect if industry sites try to attract customers with lower prices, limiting the profitability of the industry for local stakeholders (Snyder et al., 2016). Furthermore, researchers have indicated that industry profits do not necessarily flow into the public sector in countries providing care to medical tourists as significant quantities of industry profits are likely diverted out of medical tourism industry sites to foreign investors, medical tourism facilitation companies, and other stakeholders operating in the global north (Chen & Flood, 2013). This diversion of profits contributes to concerns that the industry is being oversold by the media and industry sources of information to promote industry development which is beneficial to elite industry stakeholders but provides limited economic and health benefits to communities in destination countries (Imison & Schweinsberg, 2013; Snyder et al., 2016).

Overall, global health equity concerns for the industry are multifaceted and complicated by differing measures or indicators of health equity. Health care systems are nationally bounded and thus health equity measures primarily focus on the distribution of resources within countries and compare these distribution mechanisms between countries. However, researchers contend that health equity assessments must also consider global mechanisms as the local distribution of health resources is highly impacted by complex structural processes operating at a global scale and producing vast differences in access to health resources between countries (Peter & Evans, 2001). In the case of medical tourism, health equity measures might also fail to consider how different forms and structures of medical tourism industry development differentially interact with national health care systems. For example, public health sector representatives have indicated that the growth of medical tourism practices in Barbados might actually enhance access to otherwise unavailable health care domestically if industry investment attracts medical professionals to stay when they might otherwise have emigrated for employment opportunities (Johnston et al., 2015). Meghani (2011) also demonstrates that in some health system contexts where there is an extensive private health sector (i.e., India and Mexico), resources would likely not flow back into the public sector if medical tourism practices were shut down, complicating health equity concerns for the industry based on measurable changes to the public health care system.

This dissertation takes up and nuances theoretical discussions regarding concerns for global health equity impacts of medical tourism practices by considering how structural factors inform localized medical tourism industry practices and the experiences of local populations interacting with this industry. This research builds on theoretical discussions by Smith (2012) who suggests that health equity frameworks, when narrowly interpreted, might neglect to consider how medical tourism activities inform health care provision and health outcomes via multiple social mechanisms, including global relations of power. Furthermore, academic discussions of global health equity concerns for medical tourism industry development in the global south might assume the medical tourism industry is imposed by foreign private health care facilities and industry stakeholders on communities passively accepting this development, ignoring the various ways in which this industry might also enhance access to care and other resources needed for health and well-being in destination sites (Nagla, 2012; Whittaker et al., 2010). Research suggests that elite industry stakeholders, defined here as individuals and organizations substantially benefitting from industry activities and able to adjust to industry fluctuations, live and work throughout the global north and global south, highlighting the significant role of in-country elite stakeholders in shaping industry practices in medical tourism industry sites (Ormond, 2011). The role of in-country elite stakeholders in shaping industry practices suggests that health equity impacts of medical tourism are informed by complex social phenomena informing particular practices interacting with particular social determinants of health in specific localized industry sites (Nagla, 2012). I discuss possible ways of capturing this complexity when examining health equity impacts of medical tourism in the next section.

1.2.3. Structural exploitation and medical tourism

Given the challenge of identifying health equity impacts of medical tourism activities across different health care systems, ethical examinations of industry practices warrant in-depth analyses of how different individuals occupying various social positions interact with and experience the industry to draw attention to the various ways in which industry practices might inform social determinants of ill-health (Meghani, 2011). These ethical evaluations of medical tourism will benefit from employing social justice frameworks that specifically address unfair interactions stemming from and reproducing large structural injustices such as poor access to care (Mitra & Biller-Andorno, 2013).

With this in mind, this dissertation draws on ethical frameworks including structural injustice and structural exploitation to examine the social conditions informing health inequities and mediated by the medical tourism industry. This section will provide an extensive discussion of the terms structural injustice and structural exploitation, drawing on various theories of exploitation to indicate how I use these terms throughout my dissertation.

The term exploitation is broadly defined as taking advantage of another's vulnerability to derive benefit for oneself (Snyder, 2013). The wrongful nature of structural exploitation is a contentious issue in the literature, with various descriptions of what constitutes exploitation and why this type of interaction is morally impermissible (Sample, 2003; Snyder, 2013; Wertheimer, 1999). Zwolinski (2011) asserts that the wrongful nature of structural exploitation lies in the unfair benefitting of certain parties from interactions that perpetuate future unfair transactions, informing a system of unfair interactions. The unfairness of the interaction is judged on the basis of the distribution of benefits and burdens, informed by the resulting welfare and utility of those involved in the interaction. Zwolinski (2011) argues that agents are blameworthy of structural exploitation when reinforcing and maintaining interactions that have negative impacts on the welfare of individuals.

In this dissertation, I agree with theorists such as Sample (2003) and Snyder (2013) who argue that the wrongful nature of structural exploitation lies in the degradation that occurs in these interactions. Sample (2003) asserts that structural exploitation occurs when interactions within a system or institution ignore the needs for human flourishing of the individuals in the interaction. As a result, this system enables interactions that do not respect the dignity of individuals, neglecting their needs for human flourishing as a means of maintaining and reinforcing the existing system (Sample, 2003). Snyder's argument aligns with this interpretation of structural exploitation as degradation by suggesting that the wrongfulness of structural exploitation is due to the failure of these interactions to respect the dignity of the parties whose needs for flourishing are not being met (Kissiah, 2014). This interpretation of structural exploitation differs from the conceptualization offered by Zwolinski (2011) as it focuses on the degradation resulting from the failure of parties to address structural injustices instead of evaluating the distribution of benefits and burdens. I believe Zwolinski's (2011) interpretation fails to provide adequate guidance on how to measure the supposed

benefits and burdens that are realized from different transactions as well as how to assess the fairness of their distribution.

With this understanding of the wrongful nature of structural exploitation, I consider structural exploitation to occur in cases where interactions or practices take advantage of structural injustices to maintain and reinforce certain systems or institutions, perpetuating the existence of structural injustices by failing to address the needs of interacting parties despite opportunities to do so within these interactions. Various structural injustices prevent these capabilities from being held by individuals and populations, such as economic disparities, gender inequality, and institutional racism (Young, 2003). Structural exploitation is closely related to structural injustice but uniquely wrong as degrading systemic practices produce interactions that may be unjust but not exploitative. In cases where degrading interactions perpetuate structural injustices to reinforce certain systems and institutions, these cases are both unjust and structurally exploitative (Sample, 2003).

Ethical considerations for medical tourism have suggested that practices involved in the industry may serve a degrading or repressive function when drawing resources away from the public health care sector and limiting access to health care for those unable to pay as a means of increasing profits for private health care operations (Meghani, 2011). According to the definition of structural exploitation provided above, even if overall access to health resources is not made worse compared to a baseline of no interaction, these practices may still be structurally exploitative if the parties controlling these modes of production fail to provide individuals involved in these interactions with the capabilities for human flourishing. Despite various claims in the literature about the exploitative nature of medical tourism (Judkins, 2007), there has been limited empirical research demonstrating how and why medical tourism practices are exploitative, under what conditions, and with what players serving as exploiter and exploited parties. Research examining structural exploitation in medical tourism can look for the following conditions that are likely to be found in structural exploitation according to the definition provided above: 1) existing structural injustice; 2) reliance of industry practices on the structural injustice; 3) benefit of a subset of society from these injustices; 4) failure of these beneficiaries to address the injustice. Institutions and practices that operate under these conditions can most likely be deemed as structurally exploitative.

1.2.4. Medical tourism industry development in Mexico

This dissertation focuses on examining one medical tourism industry in Mexico, a global south nation highly dependent on tourism for economic development (Berger & Wood, 2010). The medical tourism industry in Mexico has garnered significant attention both in the media and academic resources given the extensive industry development in various regions of the country (Nuñez et al., 2014). Research has indicated that government officials have promoted medical tourism industry development. The federal government has officially supported industry development as a form of tourism diversification, resulting in financial support to municipalities pursuing industry development and efforts to market and promote the industry to foreign tourists (Ormond, 2013). While this development has garnered some critical attention in the academic literature, particularly if industry competition perpetuates structural injustices via low wages (Judkins, 2007), there remains limited examination of the lived experiences and perspectives of local residents and industry employees working in particular industry sites and the conditions and contexts in which industry practices might be perceived as unjust.

Tourism is the third largest industry in Mexico (Gamez & Angeles, 2010) and government support for the tourism industry can be traced back to the 1950's (Berger & Wood, 2010). This support has included financial resources, land for industry development, and policy changes to support new tourism ventures (Mowforth et al., 2008). Critiques of tourism development as an economic development strategy highlight concerns related to the vulnerability of the industry, particularly in contexts of high competition for tourists keen to participate in lower-cost tourism activities (Gamez & Angeles, 2010). This vulnerability is particularly relevant to marginalized populations dependent on the tourism industry and who have limited alternative economic opportunities (Wilson et al. 2012). For example, in Baja California Sur, Mexico, foreign property-owners can easily move back and forth between their place of origin and Baja California Sur. At the same time, a large marginalized population is excluded from using certain areas of land along the coast and cannot access the same resources and economic gains as elite industry stakeholders such as tourist operators and tourists with higher purchasing power than marginalized local populations (Gamez & Angeles, 2010).

Additionally, natural disasters or changes to the multinational tourism industry can be devastating to populations who cannot as easily pick up and move back to other regions of Mexico or return to the global north to take up new economic opportunities in unaffected areas (Gamez & Angeles, 2010; Mowforth et al., 2008). As these examples demonstrate, even where tourism is a large contributor, if not the largest contributor, to national economies in Latin America, academics have documented how these economic gains do not necessarily translate into improved standards of living for large portions of the population, raising concern that tourism activities in many destinations might exacerbate inequalities by producing “islands of development” (Mize & Swords, 2008, p.28) within a sea of poverty (Mowforth et al., 2008). This is particularly true where tourism industry development has resulted in inequitable land use and labour practices by corporatizing property and increasing dependence on informal low-wage labour to maintain the reputations of lower-cost travel destinations (Mize & Swords, 2008).

Concerns for tourism development in many regions of Mexico are relevant to the medical tourism industry. Medical tourism industry development in Mexico seemingly occurs in areas with existing tourism infrastructure, development which has garnered significant concerns for how this might extend structural injustices to enhance profitability of tourism ventures (Mowforth et al., 2008). Researchers suggest that medical tourism industry development might develop similarly to other tourism industries in Mexico if economic benefits from the industry are concentrated in the hands of elite industry stakeholders while many industry employees and local residents have limited input into this development and remain highly vulnerable to industry fluctuations (Nuñez et al., 2014). For example, research conducted by Dalstrom (2010; 2013) emphasizes how prejudiced assumptions from American and Canadian medical tourists about medical care provision in Mexico encourages Mexican industry stakeholders to develop care which is acceptable to foreign patients by “shadowing” care provision in the United States. This “shadowing” necessitates concerted efforts to develop acceptable facilities and treatment options from different stakeholders with a vested interest in the profitability of medical tourism industry sites in Mexico (Dalstrom, 2010; 2013). The investment of public funds in medical tourism industry development in Mexico raises concerns about how this investment might divert resources necessary to promote the health and wellbeing of the public if the industry caters primarily to foreign patients purchasing services within the private health care sector (Sengupta, 2011).

Finally, ethical examination of medical tourism industry development in Mexico provides useful insight into concerns for the privatization of health care services to enhance medical tourism infrastructure (Johnston et al., 2016). After nearly 30 years since their implementation via Structural Adjustment Policies, neoliberal principles have failed to bring the millions of impoverished Mexicans out of poverty. The privatization of services such as health care have enabled economic gains to concentrate in the private sector, limiting the provision of public services. This privatization has primarily occurred through tax cuts and government subsidies for private businesses (Ruiz, 2010). The extensive provision of privately financed health services in Mexico also raises concerns about the introduction of financial barriers to health care for services not available in the public sector and the resulting health equity impacts of these barriers. For example, only 48% of dental care provision in Mexico was covered by public insurance in 2002 while dentists suggested that the public sector poorly addresses oral health problems, leaving millions of Mexicans with poor access to needed dental care (Perez-Nunez et al., 2007; Maupome et al., 1998; Perez-Nunez et al., 2006). As the majority of health services in Mexico are delivered through the private sector, medical tourism activities can easily build on existing private care infrastructure. While medical tourism activities in this context might promote economic development, as discussed above, the reliance of the industry on the private health care sector raises concerns for how industry development might extend or legitimize government support for the privatization of health care, exacerbating financial barriers to adequate care for the large number of Mexican residents living in poverty (Nuñez et al., 2014).

1.2.5. Medical Tourism in Northern Mexico

In northern Mexico, tourism industry development has been informed by proximity to the Mexico-US border, encouraging a form of tourism based traditionally on “vices” (i.e., alcohol during American prohibition) and, increasingly, on medical care at lower costs than is typically available in the global north (Dalstrom, 2013; Schantz, 2010;). Literature on the Mexico-US border region emphasizes that the region itself is not well-defined given that there are no politico-legal boundaries identifying where the region starts and stops (Fernandez, 1989). According to the La Paz Agreement signed in 1983, the Mexico-US border area includes all territory within 100 km on either side of the boundary line (Kearney, 2004). With this rather arbitrary boundary, this region has

become a site of inquiry due to its socioeconomic phenomena, whereby economic activities occurring on either side of the border are heavily reliant on the regular movement of goods and people across the border (Fernandez, 1989). Drawing on this description, I consider the northern Mexican border region to consist of all Mexican towns and cities situated within close proximity of the Mexico-US border for whom the majority of their economic activities are reliant on foreign consumption. This definition enables a coherent identification of cities and towns in this region that share similar contexts of economic development based on globalization and integration with the US economy, thus providing a foundation for analyzing this form of economic development.

Many of the industrial activities occurring in northern Mexican border towns have raised red flags about the structurally exploitative nature of their practices, suggesting that the extensive medical tourism industry development in this region might be characterized by similar unjust labour conditions to enhance profitability for elite industry stakeholders (McCrossen, 2009). The *maquiladora* industry has raised numerous social justice concerns based on poor labour conditions in the manufacturing factories employing Mexican residents with limited alternative economic opportunities (Huesca, 2004). The perpetuation of unjust labour conditions in the *maquiladoras*, including health and safety risks in hazardous occupations, low wages, and poor job protection, to enhance industry profitability is just one example of exploitation occurring in the borderlands (Arnold & Hartman, 2006; Frey, 2002). Foreign agricultural businesses have also chosen to operate in Mexico because the land is relatively inexpensive and, with over half the population of Mexico living in poverty, companies are assured access to cheap labour within flexible regulatory environments. Furthermore, proximity to the Mexico-US border facilitates the movement of goods and services for customers in the global north (Ruiz, 2010).

The conditions in which *maquiladora* activities are occurring raise concerns about a race-to-the-bottom effect producing unjust practices, such as those listed above, to maximize their profits. This race-to-the-bottom effect might occur within transnational or global industries as elite industry stakeholders seek out the right industry site to maximize profits. Sites in the global south keen to enhance their economic activities might adjust their labour standards and regulatory frameworks to entice foreign investment and industry development. By lowering standards and adjusting regulation to fit the profit-demands of transnational corporations, stakeholders for different industry

sites might encourage unjust practices to compete for investment and customers (Mize & Swords, 2010; Ong, 1999).

While medical tourism industry development in the borderlands has not received the same critical attention as the *maquiladora* industry, there are arguments suggesting this development similarly exploits asymmetries in the politico-economic contexts of the Mexico-US border to benefit industry development. This concern aligns particularly well with ethical critiques of the *maquiladora* industry as medical tourism practices in northern Mexico are often characterized in the media as providing lower cost care than other sites in the global medical tourism industry, raising concerns about practices used to compete for customers and negatively affecting labour conditions such as wages (Judkins, 2007). Media reports suggest that both Mexican and foreign-owned hospital corporations have established facilities in this region while various facilitator companies have a vested interest in the profitability of the medical tourism industry through their work connecting foreign patients to clinics (Zimmerman, 2010). Although medical tourism is a relatively new industry in border towns (Miller-Thayer, 2010), the rapid growth of the industry suggests that research on the actual experiences of people working in and interacting with the industry on a daily basis is needed to better understand the impacts of this industry on the lives of Mexicans and their access to health care, both within this region and throughout the country (Judkins, 2007).

1.3. Dental tourism in Los Algodones, Mexico

Medical tourism industry development in the Mexican borderlands region has been characterized by sites providing dental care (Miller-Thayer, 2010), bariatric surgery (Snyder et al., 2016b), and facilities to purchase pharmaceuticals and/or experimental or unproven medical interventions (Judkins, 2007; Dalstrom, 2013). This dissertation focuses on examining one case of medical tourism industry development in northern Mexico, namely Los Algodones' dental tourism industry, to develop a better understanding of how the socio-political context of this industry development and its current operation informs industry practices and the experiences of different industry stakeholders with these practices. Dental tourism is defined as the provision of dental care to foreign patients traveling out-of-country with the intention to privately purchase dental services (Judkins, 2007). Dental services are important preventative health interventions for various acute and chronic diseases. Regular visits to the dentist ensure

topical fluorides and dental sealants are appropriately applied to dental surfaces and education is provided to dental patients regarding tooth brushing and flossing habits. These interventions prevent tooth decay, periodontitis, and long term impacts of oral disease including impacts on speech, nutrition, and quality of life (Mouradian, Wehr & Crall, 2000). Furthermore, poor dental care leads to an increased risk of myocardial infarction and atherosclerosis (Meyer & Fives-Taylor, 1998). Overall, research indicates that regular visits to the dentist provide important preventative care, avoiding major oral health problems requiring costly interventions later in life, potentially prompting dental tourists to travel abroad for more affordable care (Grootendorst & Quinonez, 2011; Turner, 2007).

There is a large body of literature examining issues with access to dental care in Canada and the US. For example, in the US, children from families without dental insurance are three times more likely to have dental-related health complications than children with some form of insurance for dental care (Lave et al., 1998). In Canada, where 95% of dental expenditures are financed privately, only 64% of Canadians visit a dentist once per year, the frequency recommended by medical professionals to promote good health. The probability of a Canadian resident visiting a dentist as recommended is twice as high for Canadians from the highest income quartile compared to the lowest. Overall, these statistics demonstrate limited access to dental care for many Canadians and Americans without adequate insurance (Grignon et al., 2010). Given the inequitable access to dental care in these two countries, various population groups have complex dental needs resulting from years without appropriate dental interventions. These unmet needs likely motivate Canadians and Americans to cross the border into Mexico to access affordable dental care (Miller-Thayer, 2010).

In many Mexican towns close to the border, dental care is big business and dental professionals and companies have capitalized on proximity to the border by developing clinics in this region (Gaynor, 2009). Located on the Mexican side of the border crossing near Yuma, Arizona, the small community of Los Algodones (current population is approximately 6000 people) is a town whose economy increasingly relies on the dental tourism industry. Originally settled in 1876 by farmers, Los Algodones became a quick stopover after crossing the border and before continuing on to the larger city of Mexicali, 40 miles west. Through the 1900's, the town evolved into a small tourist stop and a residential village for nearby farms in the Colorado River delta located south

of Los Algodones (Oberle & Arreola, 2004). In the 1980's, a dentist by the name of Dr. Bernardo Magana arrived in Los Algodones to practice as the sole dentist in a town of about 750 people at that time (Henton, 2011; Stanton, 2017). According to Dr. Magana, after living in the border town and witnessing the number of tourists already crossing the border every day, he decided to expand his business by attracting tourists to use his dental services (Corchado, 2013). After marketing his dental services to foreigners already crossing the border to save money shopping in the pharmacies or grocery stores, Dr. Magana began treating numerous foreign dental patients. He has since grown his practice to include 50 dentists operating in dental clinics within Los Algodones. Other dentists have also followed Dr. Magana's lead, migrating to Los Algodones to work in the dental tourism industry. In total, approximately 350 to 500 dentists currently operate in Los Algodones (Ximénez de Sandoval, 2014) and media reports suggest that anywhere from 6,000 to 12,000 Canadians access dental care in this town annually along with thousands of American patients (Sinoski, 2011).

Along with dental tourism, other tourism-focused businesses operate within Los Algodones. For example, pharmaceutical tourism, characterized by foreigners crossing the border to purchase pharmaceuticals, is also a thriving industry in this town with multiple pharmacies selling medications at much lower costs than in tourists' home countries. Restaurants and bars in this area cater to tourists while small souvenir shops called *curios* line the narrow streets. Tourists typically spend the day in Los Algodones accessing their dental care, buying medications, and perusing the *curios* stands (Oberle & Arreola, 2004). Many tourists visiting Los Algodones cross the border by foot, parking their cars in a large private parking lot on the US side (Jacobs, 2014). While tourists visit Los Algodones for a variety of reasons, the dental tourism industry in Los Algodones has been the focus of media attention in American and Canadian news sources with reports suggesting that Los Algodones is "Molar City" with the most dentists per capita in the world operating in this town (Jacobs, 2014; Kaufman, 2013). This media narrative presents the industry as a win-win by emphasizing how the clustering of dental clinics necessarily enhances patient access to care for patients shopping around within this "dental oasis" while providing employment for local residents via tourism (Henton, 2011).

The extensive American and Canadian media coverage of Los Algodones' dental tourism industry largely informed my decision to focus my research on this particular industry site as I was interested in examining industry practices within a site commonly

visited by Canadians and with a well-established medical tourism sector. When I walked across the Mexico-US border and entered Los Algodones for the first time in May, 2015, I was surprised by the sheer concentration of dental clinics clustered near the border crossing. I was also quickly overwhelmed by information as various men, locally referred to as street promoters, were vying for my attention, offering business cards and directions to their employers' dental clinics. As I walked throughout the town over the months I lived in Los Algodones during 2015 and 2016, I came to learn more and more about the various populations employed in the industry and their role in supporting the success of different businesses operating in Los Algodones. While many (but not all) of the dentists I interviewed suggested that they are originally from Los Algodones or neighbouring municipalities or regions within the state of Baja California, most of the street promoters I chatted with during my fieldwork are deported Mexican Americans who speak fluent English and are employed by dental clinics keen to attract customers with marketing provided in English. I was also informed that the majority of *curios* vendors and employees in the local restaurants and bars are migrants from southern Mexico who have migrated to Los Algodones permanently or as part of a circuitous migration, following the tourist dollar during prime tourism season and returning home in between. Figure 2 and 3 below highlight the concentration of dental clinics in Los Algodones and affiliated employment opportunities.

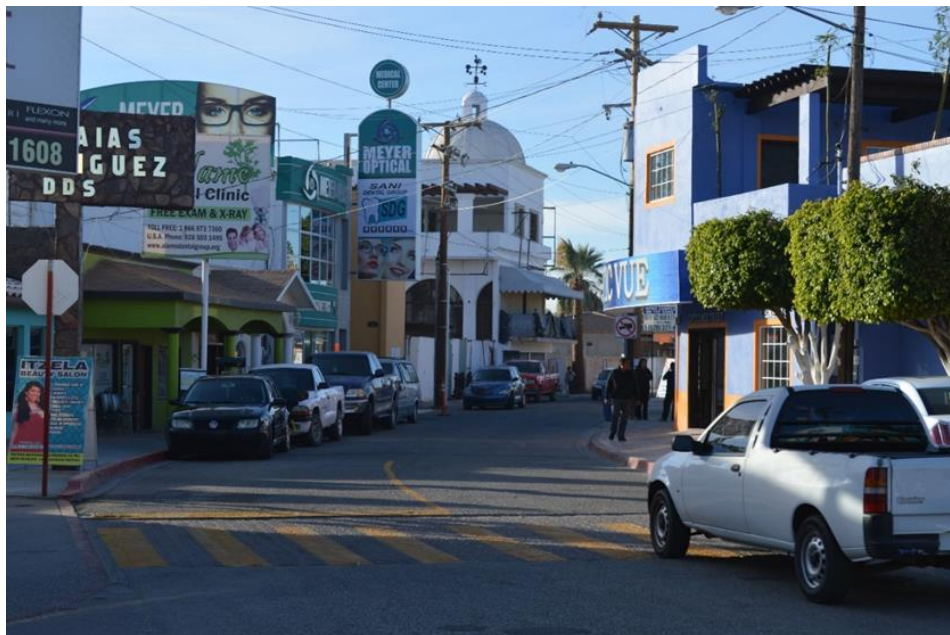


Figure 2 Dental clinics clustered on one of the main streets in Los Algodones
Photo credit: Krystyna Adams, 2015



Figure 3 Economic activities in front of dental clinics lining the streets of Los Algodones

Photo credit: Krystyna Adams, 2015

The images above illustrate how, despite being a small, rural town, Los Algodones is also a meeting point for international populations from diverse backgrounds and social positions as a result of numerous social factors shaping individual desires to participate in the dental tourism industry. This confluence of populations from such diverse backgrounds and geographic locations highlights how the border region might be a particularly rich context in which to explore ethical concerns around medical tourism. While medical tourism industry development in the global south brings together patients and providers within the private sector (Lunt & Carrera, 2010), the case of Los Algodones highlights how diverse populations from the global north and global south are also implicated in this industry development. This case also demonstrates how, despite media reports applauding the industry for expanding access to needed health care for thousands of patients, this improved access might only be available to patients from the global north despite oral health needs amongst vulnerable and marginalized populations living and working in this “dental oasis” (Henton, 2011).

Most of the local residents and employees I spoke with during my fieldwork indicated that almost all of the patients treated in the dental clinics in Los Algodones are from Canada and the US (dentists suggested they treat anywhere from 90% to 98% foreign patients). While some of these patients might decide to purchase care once

already visiting this small town, most dental clinics in Los Algodones seemingly rely on the visibility and promotion of dental clinics on the internet and by medical tourism facilitation companies recommending their services to prospective patients. As a result, these facilitation companies (often operating in the global north) participate in the marketing and promotion of the industry to enhance industry development and, subsequently, the profitability of their businesses as they are typically paid via patient fees or on commission by recommended dental clinics in Los Algodones (Dalstrom, 2012). Given that so many dental clinics in Los Algodones seemingly rely on facilitation companies to attract customers, this dependence raises concerns about how these companies might shape industry policies and practices in ways that align with their business interests while ignoring the needs and wellbeing of other industry stakeholders, particularly when operating from afar with limited understanding for how their role shapes industry practices on the ground (Meghani, 2011).

Furthermore, research indicates that, as a town whose economy relies almost entirely on medical tourism, Los Algodones' government representatives and many of the dental clinic owners work to protect the reputation of Los Algodones through various activities which ensure dental tourists are satisfied and recommend the care to other potential dental tourists (Judkins, 2007; Oberle & Arreola, 2004). For example, the town has taken numerous precautions to protect the reputation of this medical tourism industry site as a safe place to access more affordable care. According to media and academic sources, these precautions have included the presence of tourism police, secured parking lots, and the development of professional associations for dentists and pharmacists to minimize the occurrence of disruptions that might tarnish the reputation of Los Algodones as a safe town with high-quality dental services. While these precautions protect the existing flow of medical tourists across the US-Mexico border, these precautions, and other industry policies and practices described in the media, raise concerns about how the industry interacts with the everyday lives of numerous employees and local residents, particularly if these policies and practices are implemented to enhance the profitability of activities for elite industry stakeholders (Judkins, 2007). These concerns, largely informed by examinations of transnational industrial activities operating in the borderlands, influenced the development of this dissertation and my research objectives, as described in further detail below.

1.4. Dissertation rationale and structure

1.4.1. Research Objectives

As I have discussed in this introduction, Los Algodones, Mexico is characteristic of other medical border towns whose proximity to the Mexico-US border enables American and Canadian patients to take advantage of economic asymmetries on either side of the border to access desired health care. Los Algodones is unique, however, in its focus on the provision of dental care and claims by local residents that it has the highest concentration of dentists per capita in the world. While these claims are not substantiated by any empirical evidence, media descriptions of Los Algodones as the “dental capital of Mexico” and a “dental oasis” are illustrative of how the concentration is perceived by many industry stakeholders (Henton, 2011; Robbins, 2014). This industry site and the positive media portrayals of its exceptional concentration of health care resources provides a lens through which to examine how and why industry practices raise ethical concern. The study presented in this dissertation responds to a gap in the literature regarding ethical concerns for medical tourism informed by empirical research and grounded in multiple ethical frameworks (Snyder et al., 2013; Widdows, 2011). By examining the lived experiences of individuals working and residing in this industry site, this research outlines how structural factors such as global relations of power might shape localized industry practices, and particularly unjust practices. This study also aims to develop a better understanding of how and why unjust industry practices might be occurring, drawing attention to discourses about the industry and the lived experiences of particular industry stakeholders upholding an overly simplistic portrayal of the industry as a win-win activity.

Specifically, this research was informed by the following objectives: 1) identify the discourses driving dental tourism industry development in Los Algodones and analyze how these discourses are taken up and whose interests are served by these discourses; 2) describe the lived experiences of individuals interacting with the dental tourism industry in Los Algodones, highlighting the perspectives of various industry stakeholders on the impacts of the industry on their everyday lives; 3) analyze whether or not dental tourism practices operating in Los Algodones present a case of structural exploitation and identify the conditions under which this exploitation is occurring. Together, these objectives aim to develop a rich description of dental tourism practices in Los Algodones

to nuance ethical considerations for medical tourism through a structural exploitation lens.

Drawing on case study methodology, this research provides an in-depth analysis of one industry site. This methodology enables an examination of medical tourism industry practices bounded by this particular industry site (Hartley, 2004). While many of the findings and discussions presented in this dissertation emphasize industry practices which might be unique to Los Algodones, I believe these findings are relevant to other medical tourism industry sites. This critical examination of industry practices within this one site highlights the structural conditions in which unjust practices are occurring, tracing how conditions such as tourism dependence, high rates of poverty, and global relations of power interact with the industry to inform social determinants of health and subsequent health inequities. These conditions are likely relevant to other medical tourism industry sites and thus, provide important considerations for ethical examinations of medical tourism practices in a variety of contexts. However, as discussed throughout this dissertation, this research might be of particular relevance to other industry sites reliant on economic asymmetries between medical tourists' home countries and the countries where medical tourists are being treated as well as the proximity of these asymmetries that characterizes the border region (McCrosen, 2009).

1.4.2. Chapter Overviews

This dissertation is structured according to the paper-based model. It is composed of four different analyses involving three different data sets. Chapters 2, 4, 6, and 7 are standalone analytic papers with three of these papers published in academic journals and one paper to be submitted in January, 2018. Between chapters 2, 4, and 6, I have provided a short bridging or transitional chapter to situate the next analysis within the larger dissertation project and the objectives of this research. These two bridging chapters are used to describe a transition between data sets informing the analyses. Brief overviews of the analytic chapters are provided below.

Chapter 2: “The perfect storm”: What’s pushing Canadians abroad for dental care?

This chapter draws on data collected with representatives of provincial and national dental associations, dental schools, and dental advocacy groups to develop a better understanding of possible systemic factors pushing Canadians abroad for dental care. This is the only chapter in this dissertation that discusses perspectives from medical providers, policymakers, and patient advocacy groups in Canada, providing an overview of the context in which Canadians decide to participate in dental tourism. This perspective provides important insight into structural factors in the global north which contribute to the growth of the dental tourism (and medical tourism) industry in the global south, specifically highlighting privatization of care and underinsured care coverage as contributing to the growth of this global industry. As part of the whole dissertation, this chapter provides an important discussion about the socio-political factors shaping Canadians’ decisions to travel to places such as Los Algodones for care. This discussion is relevant to other analyses in this dissertation which consider how, in certain contexts, Canadian dental tourists have a responsibility to alleviate structural injustices exacerbated by the dental tourism industry as elite industry stakeholders.

Drawing on interviews conducted with fourteen participants with extensive knowledge of dental care provision in Canada, this analysis identifies systemic factors related to how dental care is financed and delivered, rising costs of dental care, and consumerism as potentially playing a role in Canadians’ decisions to purchase dental care abroad. This analysis contends that further research on individual experiences accessing and using dental care, both in Canada and abroad, could help provide a better understanding of how these systemic factors are informing Canadians’ decision-making regarding dental care, and, as a result, how to assign responsibility for ethical concerns for the medical tourism industry. This research indicates that dental tourists themselves face numerous systemic barriers to accessing needed dental care in their home countries; however, Canadians are also participating in dental tourism, an alternative care option that remains unavailable to patients unable to travel and pay out-of-pocket for care. This analysis was developed as a co-authored paper and published in the Journal of the Canadian Dental Association in 2017.

Chapter 4: Narratives of a “dental oasis”: Examining media portrayals of dental tourism in the border town of Los Algodones, Mexico

Chapter 4 of this dissertation provides a review of English language media coverage of the dental tourism industry in Los Algodones published in Canadian and American print media between 2000 and 2015. This analysis is the only paper developed from this data set and provides an in-depth discussion of common media portrayals of the industry published in common sending countries for dental tourists traveling to Los Algodones. As a critical analysis of common discourses presented in these media sources, this paper provides insight into the ways in which this industry site might be perceived and understood by prospective dental tourists. In particular, this analysis identifies the common narrative presented in these media articles and highlights how this discourse might encourage Canadians and Americans to participate in this industry while dismissing ethical concerns for industry practices and industry development in this particular context.

Drawing on an analysis of seventeen news articles, along with my co-authors, we argue in this paper that the common narrative presented by this media suggests that this particular industry site is necessarily improving access to dental care and economic development without discussing in detail for whom these health and economic benefits are provided and under what conditions or structures of control. We raise concerns regarding this overly simplified and unbalanced media portrayal of the industry as it fails to consider the perspectives of industry stakeholders on both sides of the Mexico–US border. In particular, this paper draws attention to the dominant voices in the media (i.e., dental tourists; dental clinic owners) while highlighting the missing perspectives of individuals with continued poor access to dental care and/or economic resources despite involvement in dental tourism activities in industry sites like Los Algodones. This analysis builds on current theoretical discussions in the medical tourism literature regarding how unbalanced media portrayals of medical tourism activities encourage continued industry development with limited consideration for various ethical concerns for these industry activities.

This analysis was published in the *Journal of Borderlands Studies* in 2017. As an interdisciplinary journal focused on examining how “borders” (in various forms) shape socio-political factors and lived realities on both or either side of these “borders”, this journal venue informed my decision to highlight the location of Los Algodones in the

borderlands as raising particular ethical concerns analyzing specific social conditions shaping industry development. In this analysis, I emphasize how the media ignores these ethical concerns despite a rich literature describing ethical concerns for industries operating within the northern Mexican borderlands. I return to these particular ethical concerns in subsequent chapters of this dissertation.

Chapter 6: *“Stay cool, sell stuff cheap, and smile”*: Examining how reputational management of dental tourism reinforces structural oppression in Los Algodones, Mexico

Chapters 6 and 8 of this dissertation provide analyses of data collected during nearly four months of field work I conducted from May, 2015 to May, 2016. During this fieldwork, I interviewed 43 dental tourism industry stakeholders working in the industry in Los Algodones to gain insight into their perspectives on and experiences of the industry. I also lived in Los Algodones for the duration of this field work to learn as much as possible about common industry practices and the experiences of multiple stakeholder groups, including groups not typically represented in the medical tourism literature and media sources of information. After performing thematic analysis of interview transcripts and comparing these interviews with my field notes, along with my supervisory committee, we identified two major themes emerging from these interview discussions. Specifically, we identified common discussion from participants about how desires for reputational management inform industry practices. We also found that many participants discussed patient and provider empowerment to justify and legitimize particular forms of industry development. Along with my supervisory committee, we developed each of these themes into standalone academic papers.

In chapter 6, we examine interviewees’ discussions regarding the need for reputational management of this industry site and the participation of various industry stakeholders working in Los Algodones’ dental tourism industry in reputational management activities. In this paper, we argue that many of these reputational management practices reinforce structural injustices and raise concerns for structural exploitation in the industry. Specifically, this analysis demonstrates how efforts by industry stakeholders to protect the reputation of Los Algodones’ dental tourism industry within the competitive global medical tourism industry encourage unjust practices experienced by different individuals according to nationality, race, and class.

This analysis builds on the critical medical tourism literature by discussing the conditions in which the industry might be considered structurally exploitative. We explain here how these findings build on theoretical discussions regarding health equity impacts of the industry. Specifically, we draw on interview discussions and my experiences in the field to outline how many industry practices are informed by structural exploitation as elite industry stakeholders work to protect their interests by responding to competition for customers through the introduction of unfair policies and practices. We suggest that these practices, including low wages, stressful working conditions, and exclusionary care practices, exacerbate global health inequities through the perpetuation of social determinants of ill-health such as poverty, poor access to health care, and inequitable access to resources needed for wellbeing. We also draw on these findings to contend that in-country elite stakeholders (i.e., the owners of large clinics; government representatives) play a significant role in shaping industry development according to their interests. Thus, we argue that elite industry stakeholders on both sides of the border share responsibility for the realization of unjust industry practices, particularly given their position of power in the industry. This analysis was published in *Social Science & Medicine* in 2017.

Chapter 7: *A critical examination of empowerment discourse in medical tourism: The case of Los Algodones, Mexico*

This chapter also draws on data collected during my fieldwork in Los Algodones to develop an analysis on how and why unjust industry practices are occurring in this site. Along with my supervisory committee, we provide an examination of how empowerment discourse is taken up by industry employees working in Los Algodones to mask or obfuscate the realization of unjust practices within this industry site, particularly when these injustices serve to enhance the profitability of the industry for some. We highlight in this chapter how interviewees commonly suggested that the operation of the industry within this particular site empowers care providers and local residents to access professional development and economic opportunities made possible by this flow of dental tourists across the border. Industry employees also emphasized in interviews how this particular industry site empowers patients to improve their oral health by providing more affordable and easily accessible dental care than is typically available in dental tourists' local care settings. However, we demonstrate here how these discourses are easily disrupted and complicated by the realities on the ground as numerous individuals living and working in Los Algodones do not gain improved access to dental care as a

result of the industry while economic gains from the industry are primarily afforded to elite industry stakeholders. We demonstrate how care options and employment opportunities are mostly available only to those able to pay for privately financed care and/or take up positions of power securing desirable employment, further empowering the already empowered

This chapter builds directly on the discussion developed in previous chapters of this dissertation regarding ethical considerations for the medical tourism industry by examining how the circulation of a discourse of empowerment can justify and legitimize unjust industry practices and encourage continued development according to the interests of particular industry stakeholders. This analysis builds on discussions presented in the medical tourism literature which question the economic development potential of the industry and health system development generated by the industry as cited by media resources and elite industry stakeholders poised to profit from continued industry development (see Johnston et al., 2015). Drawing on our empirical findings, we argue that elite industry stakeholders take up a discourse of patient and provider empowerment to legitimize industry development according to their interests, despite the fact that this industry development contributes to uneven economic development in this region. We contend that the concept of empowerment is taken up in this discourse to suggest the health care and desirable employment options in Los Algodones can be taken up by anyone, masking health equity concerns for the industry. We plan to submit this paper for review in *Globalization & Health*.

Chapter 8: *Conclusion*

In this concluding chapter, I revisit my research objectives and provide a discussion of how my four analyses address each of these objectives. I discuss these objectives in turn and look across my four analyses to respond to each of my research questions. This approach identifies important cross-cutting themes in my research findings and examines these findings as they build onto the existing medical tourism literature and theoretical discussions regarding ethical concerns for medical tourism. In this chapter, I discuss how this case study demonstrates that, within certain contexts, medical tourism practices might perpetuate structural injustices as they align closely with neoliberal ideas of privatization of health care and industry development which maximizes profitability for elite industry stakeholders.

Overall, by approaching ethical concerns for medical tourism using structural exploitation and structural injustice frameworks, this concluding chapter makes sense of seemingly disparate perspectives on and experiences of the dental tourism industry in Los Algodones. At the end of this chapter, I highlight how together, these analyses suggest that the implementation of policies and practices to secure the success of this industry site within a competitive global industry encourage unjust practices and exacerbate structural injustices and, subsequently, global health inequities. This ethical examination of medical tourism practices builds on academic discussions regarding health equity impacts of medical tourism industry development by focusing on how structural factors shape localized industry practices, including unfair practices with negative impacts on the health of marginalized populations. This research provides new insight on ethical considerations of medical tourism drawn from different ethical frameworks and emphasizing different ways in which the industry might exacerbate social determinants of ill-health for particular populations.

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Chapter 2.

The Perfect Storm: What's Pushing Canadians Abroad for Dental Care?

Dental tourism occurs when people travel out of their home country to access dental care abroad. In the absence of a reliable means to track patient involvement in dental tourism, we cannot know how many people are traveling abroad for particular procedures (Turner, 2008; 2009). However, academic and media reports suggest that Canadians are traveling abroad for dental care when they face barriers to access, seek care at a lower cost or both (Calvasina et al., 2015; Turner, 2009). Financial barriers are particularly pronounced for underinsured, low-income Canadians, including those using limited, publicly funded dental services and the “working poor,” i.e., those who do not qualify for public insurance or employment-based insurance (Quinoñez & Grootendorst, 2011). Underinsured and socially marginalized Canadians are reported to seek needed care options abroad (Turner, 2009; Zelniker, 2016) along with Canadian immigrants (Calvasina et al., 2015). However, much of this discussion has focused on describing pull factors and individual motivations, with only limited examination of systemic factors that could play a role in pushing Canadians to participate in the dental tourism industry (Calvasina et al., 2015; Turner, 2009).

The following analysis responds to this knowledge gap. By documenting the perspectives of targeted institutional stakeholders with extensive knowledge of the dental care system in Canada, we provide an overview of how systemic factors such as dental care financing and delivery, the rising costs of care and consumerism in dental care could push Canadians abroad for dental care. Although we do not discuss here particular contexts under which individual Canadians might decide to travel abroad for dental care (see work by Calvasina and colleagues (2015)), our objective is to highlight broad systemic factors that should be considered when researching and addressing the dental tourism phenomenon in Canada.

2.1. Methods

Between September and December 2015, we conducted eleven semi-structured telephone interviews with fourteen key informants (two interviews were conducted with multiple participants). Interviewees worked at Canadian institutions: seven in national, provincial and territorial dental associations; two at dental schools; three in provincial dental colleges (regulatory bodies); and two in patient advocacy groups. Interviews lasted approximately 45 minutes.

After all authors agreed on an interview guide, KA conducted the interviews. As the participants had different responsibilities in their organizations, the interviewer facilitated conversation by adjusting questions according to participants' areas of expertise. The questions prompted informants to discuss issues related to access to dental care in the region served by their organization, resources or programs available to Canadians struggling to access dental care and knowledge of and perspectives on Canadians' participation in dental tourism.

Participants were recruited via email sent to organizations whose work focuses on the development, regulation or promotion of dental care in Canada. All of the Canadian dental associations (provincial, territorial and national) (n = 13), English-language dental schools (n = 8) and dental regulatory authorities operating separately from the dental associations (n = 5) were contacted. We also contacted Canadian patient advocacy groups whose mandate includes promoting members' access to dental care (n = 10). Representatives of these organizations who were interested in participating were required to read the study details and provide consent before the interview.

Interviews were recorded and transcribed verbatim. Thematic analysis followed (Guest et al., 2012). The authors first met and discussed the themes that emerged from the transcripts and identified three systemic factors mentioned as producing barriers to accessing dental care in Canada. Manual coding was used to identify data relevant to each theme. The extracted data were then contrasted with the existing literature and our study objectives to assess the scope of each theme.

2.2. Results

Participants emphasized their limited knowledge of overall trends in Canadians' participation in dental tourism. However, they did suggest that when facing systemic barriers to care, some Canadians likely seek alternative care options (e.g., services provided in emergency rooms, by unlicensed dentists at home or by dentists abroad), suggesting that systemic factors could play a role in Canadians' participation in dental tourism.

The three main themes or systemic factors emerging from these discussions were financing and delivery, cost of care and consumerism in dentistry. We use quotes to report participants' views of these systemic factors.

2.2.1. Financing and Delivery

Participants raised concerns about Canadians' lack of access to adequate dental services as a result of gaps or limitations in the current Canadian dental care system (Table 1 below). Quote 1 cites over-reliance on employer-based insurance coverage to finance care, particularly for the working poor (Quiñonez & Figueiredo, 2010). Participants suggested that precarious employment (e.g., shift splitting, contract work) limits opportunities for employed people to obtain private dental insurance through work. Moreover, with yearly maximums for dental coverage increasing little or not at all, even patients with employer-based health benefits can face care needs not fully covered by these forms of insurance.

Quote 2 raises the issue of the oral health of seniors without employer-based dental insurance who are also ineligible to receive care funded by public insurance. These concerns regarding insurance coverage suggest that under- and unemployed Canadians might choose to access care abroad to save money on out-of-pocket dental expenses. Participants also emphasized that programs providing care to low-income, underinsured Canadians are geographically concentrated in urban centres, further limiting access for rural Canadians facing financial barriers to accessing care. For example, quotes 3 and 4 highlight financial inaccessibility that is amplified as a result of geographic barriers. Furthermore, even in regions served by not-for-profit clinics and

dental schools, participants suggested that their capacity to treat is limited as they rely on the availability of volunteer dentists and program funding.

Quote 5 describes concerns about financial barriers limiting access to dental care compounded by other issues not related to geography. For example, participants suggested that reduced rates for low-income patients are not always welcome if patients feel stigmatized or providers are unprepared to use this system. Overall, participant discussions highlighted how systemic factors related to financing and delivery could produce a variety of barriers to access, causing people to seek out more easily accessible and affordable options abroad.

Table 1. Participants' views on financing and delivery of dental services.

No.	Participant affiliation	Quote
1	Provincial dental association	So I looked at the 1978 fee guide and compared it to the 2014 fee guide and... fees had gone up somewhere between 200 and 300 percent. During that time, the yearly maximums for typical dental plans went up from \$1000 to \$1200.... If a patient walks into an office now needing more than a check-up and a cleaning and a couple of fillings, the first time they need a root canal or a crown... they are going to hit their yearly maximum.
2	Provincial dental association	The provision of dental care to seniors is and has been a problem for a long time. And it's not getting any better. Both the seniors in the general population have retired and possibly lost their dental plans or for seniors in long-term facilities they, they can't access care either, it's a problem with funding for them as well as access to people who can go give them treatment and facilities in homes that they can actually go and get it done.
3	Dental school	Well yeah, I mean you could come to the dental school [for more affordable care], but the problem then is you know, say you live [rurally], I mean, how often could you travel to... the dental school because dental students work more slowly than a dentist in private practice.
4	Dental school	So the problem really is, those, that group which is the lower socioeconomic group they're falling through the cracks. So in fact the Faculty of Dentistry has lots of free volunteer clinics on the weekends that are students and faculty staff that help address the need, but still we can't, it's too many people for us to take care of.... I mean, we just don't have the capacity to reach out to everyone and we do go around the province, we go to first nations reserves and do things, but the problem is we're not big enough to cover the needs, when you think of the population... and think of a third of them as people are falling through the cracks.
5	Patient advocacy group	There's also some issues with people on social assistance... you know they might need an alternative sort of model of care that isn't accommodated in private practice... private providers don't always accept the patients for those reasons, they limit how many people on these programs they see.

2.2.2. Cost of Care

Participants expressed concern about the rising costs of providing dental care, potentially limiting the amount of care actually covered by insurance and exacerbating barriers to access for under- or uninsured Canadians (Table 2 below). According to participants, regulation and safety protocols have increased costs considerably over the past few decades. However, participants emphasized that these costs are justifiable for care to be safe and effective.

One participant (quote 1) compared a dental clinic to a mini-hospital in terms of all the necessary protocols dentists must follow to meet standards set by associations and colleges. This participant agreed with many others that the costs of providing dental care are necessarily high to ensure patient safety; however, these necessary costs are not always reflected in insurance coverage, leaving Canadians underinsured and potentially motivated to find more affordable care options abroad.

Some participants also mentioned other costs, not associated with regulatory requirements, that have been introduced into Canadian dental care, creating a “perfect storm” of factors raising the cost of care. For example, in quote 2, increased dental care costs are attributed to rising fees for dental education, suggesting that dentists must charge high fees to pay back increasingly large student loans. Quote 3 indicates that for many new dental graduates burdened with large student loans, the pressure to establish a profitable business can be compounded by increasing competition for patients in urban centres, driving them to increase fees to cover their operating costs and/or promote increasingly novel treatment that might not be covered by insurance. Once again, informants suggested that rising costs related to both regulation and costs of operation could push some patients to purchase lower cost care abroad.

Table 2. Participants' views on cost of dental care

No.	Participant affiliation	Quote
1	Provincial dental association	There's a very high overhead situation, it's like a mini hospital because of all the things that have to be met.
2	Provincial dental college	One of the reasons that dentistry is so expensive and it is, there are several reasons and one is... the advent of dental insurance... that is a major changer as far as costs go because you know when you have a, when you have a dental insurance that's covering 100% of your costs... then people are willing to have whatever done they need. And so you know with dental insurance of course the fees have gone up over the last four or five decades.... But what's happened in conjunction with that is the cost of dental education... now we are at a point where there are way more dentists working for a lot less and education is a lot more and so it's almost like the perfect storm... and there's a lot of onerous things put on every dentist... to make sure that everything is as safe as it can be for your patients.
3	Provincial dental college	We know that from the data we understand that in Canada for any kind of private practice, you need 1200 to 1400 patients... to have a vibrant practice. And we know that the ratio in Toronto is about 700 and in Vancouver it's 900.... Well you know, where people are coming to for treatment and how much they are paying for treatment, that's reflected... um... I mean you are at SFU [in Vancouver] and I am sure you turn on the radio and you are bombarded by all types of advertisements from dentists about dentistry and dental practice. It's just become competitive. Very, very competitive. It's certainly driving the advertising promotion side, probably to a place we are not very comfortable with.

2.2.3. Consumerism in Dental Care

Interviews highlighted the role of cultural norms and evolving technology in driving demand for services that are not always covered by insurance companies and must be paid for out-of-pocket (Table 3 below). Quotes 1 and 2 illustrate participant perceptions that, when paying out-of-pocket for dental care, Canadians might shop around for the best value, just as they would when purchasing other goods and services. Informants expressed concern that Canadian dental patients might emphasize cost of care when deciding to participate in dental tourism or other alternative types of care when their layperson's knowledge limits their ability to judge the quality or safety of care.

Interview discussions also detailed how patients could face unanticipated out-of-pocket costs as a result of lost insurance or new diagnoses, particularly when they have

not seen a dentist for an extended period. For example, patients who have never previously paid out-of-pocket for services might be unaware of dental costs if their insurance coverage decreases (quote 3). This participant highlighted how surprise costs could also encourage Canadians to shop around for care and alternative options, potentially leading some to consider dental tourism.

Table 3. Participants' views on the consumerist model of dental care

No.	Participant affiliation	Quote
1	Dental school	In Canada if you're going to a dentist you can ask for options and if, if the person does three crowns maybe it doesn't have to be three crowns, maybe it can be one or two and I would say that most patients need to push harder on what are the other options, not the most expensive option.
2	Provincial dental association	So if somebody understands the value of their dental health, they understand they value of the care they need, in light of other costs in society, they're not going to see dental care all that expensive... any patient that walks into my office in any condition whatsoever, I can get them to the point where they're pain free and disease free and their mouth is stable and their future treatment needs are predictable for a cost of a package of cigarettes a day for a year.
3	Patient advocacy group	Maybe like a person goes to the dentist, again they've enjoyed dental insurance their entire lives, they retire, they lose their benefits and then they are told how much it's going to cost to do whatever they want to do to keep up the oral health that they're used to. And then they, they're like blown away because they'd rather use that you know \$5000 to travel or you know to enjoy their retirement and they never actually thought they'd have to pay that much.... I don't think people always realize how much it costs to pay for things if they've had insurance.

2.3. Discussion

Our analysis suggests that some Canadians face barriers to access to domestic dental care related to systemic factors: the financing and delivery of care; the rising costs of providing care safely; and increasing consumerism in dental care. Perspectives from fourteen people with extensive knowledge of dental care provision in Canada indicate that these systemic factors could play a role in the dental tourism phenomenon, although this research does not specifically suggest how these factors are informing individual decision-making as we did not consult prospective or former dental tourists.

The academic literature on international medical travel suggests that Canadian medical tourists are motivated to travel for care to take advantage of lower procedure

costs abroad, to avoid wait lists and to access domestically unavailable procedures (Johnston et al., 2012). Although our research suggests that cost could be an important factor in the decisions of Canadian dental tourists, given the systemic factors we highlight above, there could be varied motivations for Canadians to travel abroad (Turner, 2009).

Participants' discussions of access to care barriers suggested that multiple systemic factors related to financing and delivery differentially inform individuals' access to dental care. They identified barriers that are commonly discussed in the dental literature, such as insufficient insurance coverage for the "working poor" (Quiñonez & Figueiredo, 2010) and fragmented, geographically concentrated, and financially unsustainable programs for vulnerable populations ("Improving access...", 2014; Wallace et al., 2010).

However, participants also highlighted how particular systemic factors can amplify existing access challenges. For example, concerns about the limitations of programs intended to meet the needs of vulnerable populations demonstrate that diverse health determinants, including insurance status, socioeconomic status, geographic location, aboriginal status, age, mobility and familiarity with dental care, can produce overlapping vulnerabilities that exacerbate or introduce new levels of inaccessibility (Hankivsky & Christofferson, 2008). Research already shows that Canadian immigrants' decisions to participate in dental tourism are informed by multiple push factors, such as labour precariousness and language barriers, that limit adequate care options (Calvasina et al., 2015). Our findings correspond with this research by suggesting that interrelated systemic factors can exacerbate barriers to accessing dental care, barriers which could ultimately push Canadians to participate in dental tourism.

Interviews also highlighted that increasing dental costs attributed to improved safety and regulatory oversight can result in greater financial burdens on Canadian patients seeking to protect or restore desired levels of oral health, (Mckay, 2013) particularly for the third of Canadians without any form of dental insurance ("Putting our money...", 2011). Furthermore, insurance companies, public insurance and individual patients must navigate what qualifies as "good" oral health and determine which procedures are necessary to achieve this outcome within a context of evolving dental technology and shifting cultural norms. Factors such as cultural expectations of care and

technological advancement shift demands for dental care in ways that can increase costs for the patient (Mckay, 2013). Participants suggested that increasing costs of care combined with reduced insurance coverage as well as shifting social norms could push Canadians to shop around for care options, including alternative options abroad. As consumers of dental care, patients might seek the best value, unaware that higher cost care may be attributed to enhanced regulatory activities, which may not be reflected in the costs of care charged by dental providers abroad. As a result, participants generally expressed concern about the perceived growth of the dental tourism phenomenon in terms of patient safety, while acknowledging the systemic pressures that could be contributing to this growth.

Overall, this research examines how systemic barriers to accessing needed dental care might push Canadians to seek alternative care options abroad. As the means for overcoming these barriers, such as income and dental health awareness, rest very much at the individual level, Canadians might feel they have no choice but to shop around for what is perceived as lower cost, better value, or more easily accessible dental care to meet their oral health needs. Canadians' search for these care options might push them towards participation in the dental tourism industry (Calvasina et al., 2015; Lee, 2013; Ramraj & Quiñonez, 2013). The research presented in this paper demonstrates a need for further examination of potential health safety and equity concerns surrounding this phenomenon, particularly if pressure to address systemic barriers to accessing dental care lessens if individuals who are able and willing to travel abroad opt for dental tourism ("Improving access...", 2014; Ravaghi et al., 2013).

Given that we spoke with only fourteen informants from a targeted population, this research is limited in its ability to suggest the impact of dental tourism on the Canadian dental care system and Canadians' oral health. Although interviewees were highly interested in discussing the topic of dental tourism, they had limited knowledge of patients' decisions and experiences regarding this subject. Further research examining the lived experiences of Canadians seeking needed dental care, both in Canada and abroad, could provide a better understanding of the contexts in which these decisions are occurring and, as a result, how this phenomenon could affect dentistry and oral health equity in Canada.

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Chapter 3.

From push to pull factors

The previous chapter provides a discussion of possible push factors motivating Canadians to travel abroad for dental care. This analysis draws on interviews with representatives of dental associations, dental schools, and patient advocacy groups to examine structural factors shaping Canadians' decisions to seek care options out-of-country. This chapter is the only analysis that draws upon this dataset and the perspectives provided by interviewees sheds light on the structural factors shaping medical tourists' participation in the industry. While this discussion is specific to Canadians and their participation in dental tourism, the access to care issues raised in this chapter provide important considerations for ethical examinations of medical tourism practices. In particular, this analysis suggests that access to care issues in departure countries, and particularly for care commonly purchased privately, might drive individuals to participate in medical tourism.

This next chapter represents a shift in focus from push factors to pull factors. More specifically, this next analysis considers how media coverage on Los Algodones' dental tourism industry portrays the industry. By examining this common narrative and the possible assumptions presented in this media discourse, this analysis provides further insight into the types of information shaping prospective dental tourists' decision-making and interactions in the industry. This chapter suggests that media coverage of Los Algodones' dental tourism industry is overly positive and ignores important ethical concerns about medical tourism industry development. We argue that the circulation of this discourse by industry stakeholders with a vested interest in the profitability of the industry might encourage unjust practices and the participation in these practices by a range of stakeholder groups, including medical tourists.

Chapter 4.

Narratives of a “dental oasis”: Examining media portrayals of dental tourism in the border town of Los Algodones, Mexico

4.1. Introduction

This paper provides an examination of common discourses presented in media depictions of the dental tourism industry in the small border town of Los Algodones, Mexico. Dental tourism is the term used to describe the practice of individuals accessing dental care outside their home countries that is paid for out-of-pocket (Conti et al., 2014). By examining American and Canadian media portrayals of dental tourism activities in one particular industry site, this analysis identifies the common narrative used by media sources in places most commonly marketed to by the dental tourism industry (Mainil, 2011). This paper critically analyzes this narrative, which we contend fails to account for ethical concerns related to global health equity and structural exploitation.

We selected this location as the focus of this analysis because it is situated right at the northern Mexican border, about four km south of Yuma, Arizona, and is very well known for its widely established dental tourism sector (Miller-Thayer, 2010). By selecting media about one particular site of industry development close to a border between two nations, this analysis examines how the media discursively produces a depiction of industry practices as enhancing access to health care within a globalized market place close to the border crossing (Oberle & Arreola, 2004). In this exceptional case of a concentrated dental tourism border town, we suggest that the intense clustering of dental care resources raises specific global health equity concerns. These concerns are particularly relevant to dental care given the highly inequitable nature of oral health globally (Sheiham et al., 2011). In addition, the context of this industry site also raises ethical concerns regarding potential structural exploitation in the industry. As dental tourism is by far the dominant industry in the town, elite industry stakeholders are at a particularly elevated position of power to establish town policies with personal benefit and legitimized as enabling industry development while other residents and employees remain vulnerable to these policy and industry fluctuations (Cheong & Miller, 2000).

These considerations are not addressed by the media discussions of Los Algodones' dental tourism industry.

To further our argument, we draw on Gloria Anzaldua's (1987) theory of borders as socially and ideologically produced. Anzaldua (1987) argues that borderlands should not be understood only as a particular geographic location but also in terms of the social hierarchies that are produced by borders and extend beyond a particular geographic region (Orozco-Mendoza, 2008). We argue that the media on dental tourism in northern Mexico ignores how the industry interacts with these hierarchies. Drawing only on the voices of dental tourists and dental clinic owners, this media portrayal fails to present a more complex and critical view of the industry that considers how its development could perpetuate structural injustices by concentrating industry benefits amongst elite stakeholders, particularly given the private and unregulated nature of the medical tourism industry (Crooks et al., 2013; Ormond, 2011). Before providing a description of the common media portrayal of Los Algodones in Canadian and American news sources, in the section that follows we provide a succinct introduction to the practice of medical tourism and to Los Algodones.

4.2. Background

4.2.1. Dental tourism in the media

The academic literature on medical tourism, the broad term referring to all travel abroad for biomedical interventions, has criticized media portrayals of medical tourism as failing to present ethical concerns that medical tourism causes health inequities, understood as differential health outcomes resulting from health resources shifting from the public to private sector; health resources concentrating in certain geographic areas, displacing resources from other regions; and health resources being used for particular forms of care based on profitability instead of need (Crooks et al. 2013; Snyder & Crooks, 2012). Without being able to track the numbers of medical tourists traveling to countries such as Mexico, researchers have acknowledged the challenge of assigning health equity impacts to this practice (Adams et al., 2013). Instead, much of the research on medical tourism has focused on analyzing political and popular discourses regarding medical tourism in destination countries to better understand how the industry might shift

health care practices or policies as well as industry development in places such as Los Algodones (Mainil et al., 2011; Ormond 2011; Pocock & Hong Phua, 2011).

News media depictions of the industry in Los Algodones are well poised to contribute to popular discussions of medical tourism practices in industry sites such as Los Algodones by including contextually relevant ethical concerns informed by diverse perspectives (Alvarez, 2012). Research suggests that health equity impacts of medical tourism are complicated by various systems-level processes informing poor access to health care across local, national, and global contexts (Snyder et al., 2013; Meghani, 2010). For example, while some medical tourists have opportunities to access more affordable care based on lower costs of private care in particular destinations, many patients may still be unable to afford to travel for health care. As a result, access to health care for individuals unable to travel for their care may be further disrupted if discourses of medical tourism, including media discussions, reduce political pressure to change domestic health care provision (Johnston et al., 2010). Furthermore, while some individuals in medical tourism destination communities may gain economically from the development of the industry in ways that enhance their access to health care, others may face enhanced barriers to accessing care as a result of shifting health resources and/or increased costs of care with the influx of foreign patients (Snyder et al., 2013). As these examples demonstrate, discussions of the industry should resist presenting overly simplistic depictions of the impacts of the industry on health equity and other social justice indicators given the complex contexts within which individuals access health care and interact with the industry (Adams et al., 2013; Imison & Schweinsberg, 2013).

4.2.2. The borderlands

The border region between Mexico and the US attracts visitors and migrants for a variety of reasons. Mexicans migrate to the northern border region in hopes of increased access to needed resources, whether it be through employment in one of the many industries populating the Mexican side of the border or opportunities to ultimately cross into the US (Orozco-Mendoza, 2008). Individuals from both sides of the border are also drawn to this region for economic reasons as the border crossing enables the movement of goods between nations as part of the manufacturing industry whereby large corporations taking advantage of border flexibility to enhance industry profitability (McCrossen, 2009; Ong, 1999). Furthermore, the convergence of economic

asymmetries at the Mexico-US border also draws individuals to take advantage of service-oriented industries, including medical tourism (Dalstrom, 2013).

With these border movements in mind, the borderlands should not only be spatially defined based on proximity to the physical border crossing; instead, they must be ideologically defined by the power relations and structural injustices maintained and reinforced by this demarcation that enable the global capitalist market to flourish (Anzaldúa, 1987). In the case of dental tourism along the northern Mexican border, industry resources and profits are likely taken up differentially amongst industry stakeholders depending on how these power relations operate within contexts of tourism, migration, poverty, and a growing private biomedical industry, amongst others (Dalstrom, 2013; Ruiz, 2008). Furthermore, the movement of skilled resources, such as health human resources, to urban centres and tourism destinations within Mexico, might result in the establishment of 'zones of abandonment' wherein certain populations have limited access to health resources as a result of the concentration of resources taken up by particular populations (Biehl, 2005; Mize & Swords, 2010). Concerns regarding 'zones of abandonment' are relevant to export-oriented communities in northern Mexico, whereby economic gains and access to resources have only occurred in small pockets within a sea of underdevelopment. The majority of economic gains from activities within these "islands of development" have been concentrated in the hands of the wealthy elite or have left the country via foreign ownership (Mize & Swords, 2010, 28). Residents on either side of the Mexico-US border face systemic barriers to accessing health care despite the overabundance of health human resources, including dentists, in particular urban centres or industrial areas (Williams, 2014). Given the extensive documentation in the literature on health disparities and injustices informed by industries extending throughout and beyond the geographical borderlands, our critique presented below considers how the media ignores this literature in favour of a narrative that presents the industry as win-win for all stakeholders (McCrossen, 2009; Ruiz, 2010). To critically examine these media discourses, we next present an overview of our study site to provide context for our analysis.

4.2.3. Los Algodones

Along the northern Mexican border, there are numerous 'medical border towns' whose primary industry focus is medical care, providing medical services to tourists with

easy access from the US border (Dalstrom, 2013). Los Algodones is the only industry site that focuses solely on one type of medical tourism, dental tourism, while other medical border towns provide a range of medical services including surgical care and general medicine (Dalstrom 2013). As a result, this industry site is an exceptional case and warrants particular attention and ethical consideration.

The town of Los Algodones was originally settled in 1876. Through the 1900's, the town evolved into a small tourist stop and a residential village for nearby farms (Oberle & Arreola, 2011). In the 1980's, a dentist by the name of Dr. Bernardo Magaña moved to the town of 750 people to practice as the sole dentist (Henton, 2011). According to Dr. Magaña, after living in the border town and witnessing the number of tourists already crossing the border every day, he decided to expand his business by attracting tourists to use his dental services (Corchado, 2013). After marketing his services to American residents already crossing the border, Dr. Magaña began treating numerous foreign dental patients. He has since grown his practice to include 50 dentists operating in dental clinics within Los Algodones. Other dentists have also followed Dr. Magaña's lead, migrating to Los Algodones to work in the dental tourism industry and contributing to the current clustering of approximately 500 dentists within the four-block radius of the town (Oberle & Arreola, 2004).

Today, the majority of Los Algodones' 8000 residents are employed in the dental tourism industry in some capacity. The Gross Domestic Product (GDP) per capita is approximately \$18,750 USD, about 87% higher than the average GDP per capita in the rest of Mexico, attracting individuals from other parts of the country to seek out employment in industrial towns along the northern border. As Los Algodones' economy relies almost entirely on medical tourism, the town has taken numerous precautions to protect this sector. For example, tourism police, secured parking lots, and dentists serving in municipal governance minimize the occurrence of disruptions that might tarnish the reputation of Los Algodones as a safe town with high-quality dental services. While these precautions protect the existing flow of medical tourists across the Mexico-US border, they may also further establish the dependence of this town on this industry and prevent the emergence of alternative economic activities for residents unable to work within the tourism sector (Judkins, 2007).

4.3. Methods

To analyze news coverage of dental tourism in Los Algodones, we used discourse analysis to examine the content of media articles written on this topic. Discourse analysis methodology examines how ideologies emerge within discourse by identifying references to value judgments, group relations, and societal roles that are assumed to be inevitable. We used discourse analysis to critique the common narrative presented in the media about dental tourism in Los Algodones and identify assumptions about the industry that might ignore particular industry practices, resulting in a biased representation of the industry (van Dijk, 2011).

To conduct this discourse analysis, we searched Google News and Factiva search engines for English-language news articles related to dental tourism in Los Algodones from American and Canadian news sources and published online between the years 2000 and 2015. We chose to analyze media articles published in American and Canadian media sources as we wanted to capture depictions from abroad, therefore focusing on media coverage in common patient homes. We chose to limit our search to these years to ensure we only analyze current media depictions of the industry. We used the search terms “Los Algodones” and “dent*” as well as “Mexico” and “dent*” at first to search for relevant articles in the search engines. This initial search identified 50 articles that mentioned Los Algodones or dental tourism somewhere in the article. We then identified seventeen articles for further analysis whose content directly focused on describing the development of and/or the current scope and structure of the dental tourism industry. The other 33 articles did not substantially discuss the dental tourism industry in Los Algodones, either focusing on dental tourism in another location or describing Los Algodones’ other tourism sectors. See Table 4 below for a summary of the article sources included in this analysis.

Table 4. Reviewed news articles

Publication Year	News Article Title	News Source	Type of Publication
2015	How the world waits for health care	Toronto Star	Canadian municipal news, print and online
2015	U.S. Seniors head to Mexico for cheaper dental care	CBS News	American national news, online only
2014	A reason to smile: Mexican town is a destination for dental tourism	NPR	American national news, online only
2013	Albertans beating a path to Mexico and other countries for discount dental work	The Calgary Sun	Canadian municipal news, print and online
2013	Dental tourism on the rise, especially from Alberta	The Calgary Sun	Canadian municipal news, print and online
2011	The Molar City Magnet	The Edmonton Journal	Canadian municipal news, print and online
2011	Canadian snowbirds flock to Mexico's 'Molar City' for cheap dentists	The Wall Street Journal	American national news, print and online
2011	Americans head to Mexico for cheap dental care	KPBS	American national news, online only
2011	Cheap dental care draws Alberta snowbirds	The Edmonton Journal	Canadian municipal news, print and online
2011	Canadians flock to Mexico for tooth care	The Vancouver Sun	Canadian municipal news, print and online
2011	Dental work in Mexico a roll of the dice	The Edmonton Journal	Canadian municipal news, print and online
2011	Mexico a dental Mecca	Saskatoon Star Phoenix	Canadian municipal news, print and online
2011	Canadians head south to Molar City	The Calgary Herald	Canadian municipal news, print and online
2009	For cut-rate dental care, head to Mexico	CNN	American national news, online only
2008	Tourists biting into cheaper prices for dental work in Mexico	The Arizona Republic	American state news, print and online
2007	Sun, sand... and root canal	The Toronto Star	Canadian municipal news, print and online
2005	Elderly, town help each other	USA Today	American national news, print and online

We entered the seventeen articles into NVivo qualitative data management software to thematically categorize the content of the selected articles according to the following discourse-informed concepts: the border; access to health care; rationale for the industry; and governmentality. We also identified the interviewees and sources of information presented in the article to identify which voices were being used to produce this depiction of the industry. We selected these categories after initially reading the articles and identifying a distinct common narrative presented by this media. We read

through the text coded in each thematic category to identify how this media discourse is developing this common narrative and critique this narrative from a health equity lens. Before sharing our critiques, in the section that follows, we first outline the common narrative depicted in the 17 media articles we reviewed.

4.4. Findings: Media Narratives of Dental Tourism in Los Algodones

American and Canadian media suggest that the emergence of dental tourism on the northern Mexican border is akin to “any competitive marketplace” offering competitive prices and a variety of treatment types (Browne and Joffe-Block, 2011). Much of the media content provides descriptions of the dental care offered to emphasize the reportedly high standards of care available in Los Algodones. These media reports present dentists in Los Algodones as “chaf[ing] at suggestions that their work is inferior” to care provided elsewhere (Ellingwood, 1999). The articles use quotes from dentists and patients that refer primarily to the aesthetics of dental offices and dental equipment as evidence of the high standards of care. For example, one article described dental clinics as “modern, immaculately clean and [...] bright, comfortable exam rooms [...] like a typical US office, except that the staff is Mexican and bilingual” (Zimmerman, 2010). Mexican dentists practicing in Los Algodones draw on American standards, training, and aesthetics to indicate their services as being of high quality. According to one dentist: “everybody works with gloves and a mask. The technology is the same. Some of our equipment is the newest available” (Mann, 2011), comparing the equipment and dental procedures to what patients might see and experience in the US. The media reports highlight dentists’ efforts at making their “practice mirror [patients’] experiences in the US” (Zimmerman, 2010), emphasizing there are familiar standards and aesthetics of care provided in the Los Algodones’ dental clinics.

According to the reviewed media reports, dentists in Los Algodones face the challenge of convincing foreign patients that despite “costs up to 70% cheaper than in the US”, the care they provide is of high quality (“Medical tourism offers hope”, 2007). The reviewed articles typically highlight the comparatively low cost of dental care in Mexico to emphasize the role of this dental tourism industry in expanding Americans’ and Canadians’ access to needed dental care. For example, one of the articles depicts the following story of a dental tourist’s journey to Los Algodones:

[Mike] drives tractor-trailers. He has since 1984. Over the years, he admits to eating a lot of roadside food and not making a lot of trips to the dentist. So by the time he went to see his dentist in Fargo, North Dakota, he was told it would take \$20,000 to quell his many toothaches. Instead, Mike looked for other options. 'Know where to find a good dentist in Mexico?' he asked someone he met on the road. 'Yes, Go to Los Algodones,' she said. Which he did. Mike made eight trips in six months for a total of four root canals, four crowns, five fillings, a teeth cleaning, a deep cleaning, and laser whitening. He's not done. Soon, he'll also get two new implants and a permanent bridge. This was going to cost \$20,000 in the United States. In Mexico, it cost him \$3,800 [...] (Browne & Joffe-Block, 2011).

The media narratives focus on describing the cost savings for expensive dental interventions such as crowns and implants and suggest that these interventions can be accessed within full-service clinics. The articles highlight the sheer size of some of the dental clinics that are owned by large private dental groups operating throughout Mexico, suggesting that these clinics have the ability to make the necessary equipment on site and treat patients quickly so they can return home as soon as possible. The articles emphasize that many clinics have their own labs and that with hundreds of dentists operating in Los Algodones, this industry site is really a one stop shop for efficient and high-tech dental care (Robbins, 2014). The articles also commonly emphasize the ease of physically getting to Los Algodones for Americans and Canadians, further emphasizing the ease with which dental consumers can participate in the industry to save time and costs. For example, one article stated that:

Or you can step across the U.S. border and cut your tab to \$250. That's the going rate for a crown at DentiCenter, a small but growing chain of full-service dental centers lining the U.S. border along California, Arizona and Texas. DentiCenter's six outposts are located in Mexico, but 97% of its patients come from the U.S. (Zimmerman, 2010).

A common narrative presented in the media, namely that care in Los Algodones is of high quality and is easily accessible, emphasizes the inclusion of medical tourism facilitation groups that help arrange travel details and book the dental procedures at preferred dental clinics. Some of the articles suggest that the facilitators help make patients feel safe and comfortable as they do not need to navigate travel planning and transportation in a foreign country (Rothe, 2007; Zimmerman, 2010). The narratives also suggest patients can stay in a familiar environment by lodging in hotels on the American side of the border and crossing the border only to get care:

Well-marked dental offices hover closely over border crossings, vying for a piece of the discount toothy trade. Ron Vinluan's Phoenix-based dental brokerage company Dayo Dental runs a 3-1/2- hour van shuttle of six to 10 people a time, up to four times a month to the Yuma, Ariz. side of the border. From there, patients walk across the frontier into a tooth care bazaar where they'll find themselves reclining and receiving anesthetic within minutes (Kaufman, 2013).

Many of the articles briefly mention the presence of police and military forces in Los Algodones, emphasizing the added safety this presence brings for the tourist. The media focuses much of its attention on resisting assumptions that northern Mexico's border region is a dangerous place for visitors, stating that, "The town is tightly controlled and anyone who upsets the flow of dollars is whisked away by the tourist police" (Rothe, 2007). Many of the articles spend time describing the amenities available for tourists, interviewing previous patients about their positive experiences accessing dental care in Los Algodones, further underscoring the idea that Los Algodones is a safe and enjoyable destination for dental care. This emphasis of Los Algodones as a desirable tourist destination portrays the town only from the perspective of the foreign tourist who can easily cross the border without even showing his or her passport and cross back with cleaned teeth and souvenirs. As a result, Los Algodones truly becomes a "dental oasis" (Henton, 2011), a place drawing on American aesthetics and globally recognized biomedical care with clusters of private dental care whose prices reflect the Mexican economic context (Judkins, 2007).

Along with discussions of patient journeys, the media articles also devote much of their content to describing the journeys of the dentists and other entrepreneurs that have helped develop the industry in Los Algodones. Many of the articles emphasize how the dental tourism industry has cleaned up the town from its "dusty" and morally questionable past to a more "modern" town where "business is booming" (Browne & Joffe-Block, 2011). In particular, the media suggests that the industry has created jobs for numerous residents of the area. The quote below exemplifies the typical discussion of how Los Algodones came to be the "dental capital of Mexico" (Robbins, 2014):

[When he first arrived], Los Algodones was a dusty border town. Magaña remembers that there were no less than 48 cantinas. Still, he sensed that if he put his practice here, people would come, Americans would come. He started advertising on television in the U.S. He became mayor and shut down the cantinas and the brothels. He worked and worked and so they came — not only more American patients, but also more Mexican dentists.

The dentists moved into the empty spaces the cantinas and brothels left behind (Browne & Joffe-Block, 2011).

Broadly speaking, the overall narrative shared by the reviewed articles is of the dental tourism industry enhancing access to dental care for Americans and Canadians while providing jobs and economic development to the town and border region in northern Mexico. In keeping with this, the articles typically conclude by presenting the industry as a win-win for all industry stakeholders and maintain that the industry will grow because it is beneficial to everyone involved:

He was told the extensive dental work he needed – his teeth needed to be raised and he needed a crown on every molar – would cost \$65,000 at a private dentist. He worked for lower rates, finding a dental school where the work was less expensive because it was performed by students. But it still cost \$35,000. He paid \$3,000 in Mexico [...] (“U.S. Seniors”, 2015).

Juan Manual Comacho has branched out, opening a restaurant and a new Main Street shopping plaza with a few partners. Comacho was one of the original six dentists in Los Algodones, starting his career as an associate of one of the town’s first dentist, Bernardo Magana. He has resisted the urge to expand into specialized dental procedures. A 61-year old grandfather, Comacho has his eye on retirement as he practices general dentistry in a clinic by the border gates with his pediatric dentist wife. He hopes to one day turn his practice over to one of his four children. (Henton, 2011).

While the media articles almost all present the dental tourism industry as being a win-win for everyone involved, one article diverges from this common narrative at certain points. This article presents stories of patients’ and dentists’ experiences; however, it also offers a critical assessment:

Essentially, the market sets the bottom line. Which means that along the border, it is a constant race to the bottom to lower and lower prices. One economist, Michael Ellis from New Mexico State University, calls this an example of a “medical maquila,” not unlike the factories along the border that produce goods for the U.S. market. “The medical maquila model has been talked about for the last decade,” Ellis said. “It’s just beginning to take hold, but I think the pressure will build as the boomers retire” (Browne & Joffe-Block, 2011).

This article highlights the structural injustices informing the development of the industry as numerous Americans and Canadians struggle to access dental care while the economic context in Mexico facilitates the development of a dental tourism industry offering care at lower costs than typically available in Canada and the US. This article

suggests that pressure to compete in the global medical tourism industry might actually drive down prices and as a result industry wages, reinforcing the structural injustices underlying the industry's development, much like with the manufacturing industries operating within the *maquila* factories located in northern Mexico (Browne & Joffe-Block, 2011). This critique of the exploitative nature of borderland industries along with critiques of medical tourism as potentially exacerbating health inequities informs the remainder of this paper as we examine how the media narrative fails to these raise important ethical considerations.

4.5. Discussion

In the previous section we summarized our analysis of seventeed media articles focused on the dental tourism sector in Los Algodones, a small border town in Northern Mexico. We found several recurring narratives, including the emphasis on the low cost of care, the availability of high quality procedures, the emphasis on “modern” care aesthetic (Browne & Joffe-Block, 2011), the safe nature of the local environment, the accessibility of travel and lodgings, and the entrepreneurial nature of those who have established this sector. Collectively, these heavily positive narratives point to the fact that media coverage is supportive of this sector and encourages the movement of international patients considering accessing dental care in Los Algodones. In the remainder of this section we apply a critical lens to these narratives, paying particular attention to ethical and equity issues either emerging from these narratives but not explicitly discussed or ignored in the popular media.

4.5.1. Dental care in the borderlands

The common overall media narrative on dental tourism in Los Algodones produces a particular depiction of the type of dental care provided in the clinics that populate a four block radius of the town (Judkins, 2007): it is care that is of high quality and affordable, provided in a familiar aesthetic in a location that is safe for visitors and easy to access. Our review points to the fact that most media sources equate “modern” dental aesthetics such as high technology machinery and pristine waiting areas with care quality (Browne & Joffe-Block 2011). In other words, there is an underlying assumption that care aesthetics are indicators of care quality. This assumption is

concerning. First, it disrupts the possibility of other types of care, particularly care which is tailored to meet the needs of the community within which the dental practice is situated (Johnston et al., 2010). Second, typically dental tourists are only traveling once they already have many oral health problems (Miller-Thayer, 2010). As a result, the care provided within dental tourism clinics focuses on interventions aiming to correct significant oral health problems, potentially overshadowing low technology services focused on more preventative care, both for the local communities and dental tourists (Miller-Thayer 2010; Meghani 2011). Finally, this assumption hides the fact that while dental tourists can access desired treatments in Los Algodones, without continuity of care, they may not take the necessary measures to prevent future complications from arising, increasing burdens on finite dental resources and lessening their overall oral health (Johnston et al., 2010). Overall, these discussions related to quality of care ignore potential health equity impacts of the industry if services emphasize the use of resource-intensive medical solutions with limited emphasis on oral health promotion and systemic changes important for addressing oral health inequities (Williams, 2014).

We believe the news media also fails to discuss how the type of care provided in dental tourism clinics might shift dental tourists' expectations of care upon return home. The dental tourism industry model in Los Algodones relies on "full-service" (Zimmerman, 2010) dental clinics that can treat patients quickly with dental labs operating right next to clinics at all hours of the day (Judkins, 2007). Patients' expectations might change as they experience a fast food-like style of dental care that prioritizes speed of care and volume of patients to maximize profit for the dental clinics and ensure patients can get all the care they want done within their limited holiday time. These changing expectations might create pressure on other dental care systems to adjust their style of care despite potential negative impacts on the health and safety of the patient as well as the equitable distribution of oral health resources (Johnston et al., 2010).

An overwhelming majority of the seventeen articles we reviewed pointed out that "Los Algodones has become known as having more dentists per capita than anywhere else on Earth" (Kaufmann, 2013), focusing attention on the concentration of dentists that are practicing in this one small border town. By relying heavily on dental tourists as sources of information for the media content, these articles shine a positive light on this intense spatial concentration of health professionals, suggesting this concentration is enabling patients to shop around for their ideal care like any other resource in the market

place (Conti et al., 2014). Meanwhile, the media fails to address health equity concerns related to the concentration of health professionals working within one particular industry and treating patients in one geographic location, potentially disrupting or denying access to dental care elsewhere or for patients unable to participate in the industry. There are many areas of Mexico experiencing slight to extreme shortages of medical professionals, including dentists (Novelo-Arana et al., 2013), while this particular border community is oversupplied relative to local need, raising important concerns about how dental tourism industry development could limit opportunities and political will to address dental care shortages in particular communities (Johnston et al., 2010)

Furthermore, the media's depiction of the type of dental care provided in the dental tourism industry in Los Algodones assumes that the procedures being accessed are necessary forms of care (Mann, 2011). While patients deciding to participate in this industry might be informed that procedures are required by their home dentist, it must be understood that recommendations for care provided by dentists in wealthier countries like Canada and the US are based on the national and local resource availability and health care norms (Homedes & Ugalde, 2002). While Mexico actually has a higher ratio of dentists per 10,000 people than Canada (Novelo-Arana et al., 2015), many Mexicans lack purchasing power to use these services, producing an oversupply of dentists with limited patients to treat. Despite large numbers of Mexican dentists being trained since the 1970's, oral health outcomes have not improved as many Mexicans are unable to afford the care provided within private dental clinics and dentists are unable to work in the public system due to a limited number of positions (Maupome, Borges & Diez-de-Bonilla, 1998). In fact, research indicates that only 48% of the general Mexican population in need of oral health care receives treatment (Perez-Nunez et al., 2006). Dental tourism provides job opportunities for underemployed dentists in Mexico and enhances treatment availability to dental tourists from the global north. However, it does so by potentially exacerbating oral health inequities between those that can afford private care and those that cannot (Sheiham et al., 2011). The realities of dentistry in Mexico indicates some dentists potentially migrated to Los Algodones not only as heroic entrepreneurs, but also out of economic need and lack of alternative employment options. As a result, dentists and other industry employees with limited alternative employment options might be vulnerable to potential exploitation, particularly as competition between clinics in Los Algodones and other dental tourism sites could place

pressure on employees to attract customers with lower prices or other efforts that limit benefits to many employees in Los Algodones (Dalstrom, 2011).

Finally, the news media portrays dental care as easily accessible to tourists and residents near Los Algodones based on the stories of dental tourists safely and efficiently crossing back and forth over the border. By highlighting those that “are very lucky to live near enough to Mexico to get good healthcare at a reasonable price” (Gaynor 2009) without addressing the policies and activities related to the border and tourism industry that establish this secure access, the media ignores the power relations and structural injustices implicated and potentially even perpetuated by industry activities (Cheong & Miller, 2000). The media we reviewed suggests that the town is patrolled by police officers and security guards (Browne & Joffe-Block, 2011); however, the media never questions how these security measures impact the daily lives of residents in Los Algodones and whether these measures enhance the physical safety of residents as well as tourists. Research on the northern Mexican border region indicates that violence, both in the physical and economic sense, is pervasive as large inequities in access to resources and power facilitate violent actions such as policy brutality and wage theft (Marrujo & Pulido, 2010). These forms of violence limit the safety and well-being of residents living in this region, despite the heavy presence of security forces and as a result, may also limit residents’ ability to access the health resources securely and cost-effectively provided to tourists. Furthermore, dependence on the dental tourism industry for employment raises concerns regarding structures of control that could take advantage of these vulnerabilities to enhance industry profits for elite populations, concerns largely ignored in the media portrayal of Los Algodones.

4.5.2. Journeys to the borderlands

The previous section describes the ways in which the media discursively produces an assumption that dental tourism is occurring within a “dental mecca” (Henton, 2011) that expands access to health care in ways that are necessarily positive and beneficial for all stakeholders involved. While we critiqued this assumption based on particular industry practices documented in the media and literature, here we build on this argument by discussing the journeys and experiences of individuals and communities not made visible in the media but potentially implicated in the dental tourism industry in Los Algodones. Anzaldúa’s conceptualization of borders depicts

these boundaries as taking on different meanings to individuals within different contexts as cultures and practices mix, transform, and as a result, redefine our understanding of space and place (Anzaldúa & Keating, 2009). In the following section, we demonstrate how Los Algodones might be perceived as a place of hope for tourists and economic migrants or a medical mecca for dentists and dental patients. However, this town can also be characterized by stories of inequalities and injustices as a result of its location at the northern Mexican border, “the open wound where the third world grates against the first and bleeds” (Anzaldúa, 1987). In this section, we present a more nuanced understanding of how different individuals might interact with Los Algodones’ dental tourism industry within very different contexts, emphasizing the failure of the media to portray the industry from multiple perspectives.

First of all, the journeys of patients and dentists to Los Algodones are characterized in the media as journeys of ‘savvy consumers’ and ‘heroic entrepreneurs’ that travel to the border region in search of job opportunities or affordable health care. Through the media emphasis on particular industry stakeholders, descriptions of the industry ignore the journeys of individuals that have moved to the town in search of employment, opportunities to emigrate to the US, or through forced deportation (Wheatley, 2012). The media never discusses how or why the population of the town has increased more than ten-fold in the past 40 years or why so many residents of Los Algodones speak English (Judkins 2007). By ignoring certain contextual elements, the media presents the industry as universally beneficial, an extension of dental care in the global north, without considering the structural injustices that enable this industry to flourish and that might be perpetuated by industry activities. For example, the literature suggests that many of the people living and working in northern Mexican towns are actually deported Mexican-Americans. With their families still living in the US, many deportees take up residence in towns with work opportunities in the various industries populating this region (Wheatley, 2012). The dental tourism industry provides a stable income for these employees (Judkins, 2007); however, as a result of border politics, these employees must also watch Americans and Canadians easily cross the border on a daily basis while they remain separated from their families as a result of these same border policies (Wheatley, 2012).

Furthermore, individuals might journey to Los Algodones from southern Mexico and Central American countries in search of new job opportunities, particularly as

seasonal workers selling souvenirs in the *curios* stands lining the streets of Los Algodones (Judkins, 2007). However, the media never discusses the origin of the residents of the town and the structural injustices informing their search for employment opportunities such as those resulting from the North American Free Trade Agreement and other global economic agreements (McCrossen, 2009). Furthermore, while friends and family members can benefit from remittances sent back from the industry, they must also live separated from their loved ones while experiencing their communities turn into “ghost towns” as work becomes increasingly scarce (Cohen, 2004). Additionally, undocumented migrants living in the US are unlikely to cross the border to access dental care as they might not be able to safely return back to their home in the US without required documentation to cross the border (Wheatley, 2012). The media never considers those left behind when patients and dentists leave, ignoring how these journeys could disrupt or fragment health resources and the political will for systemic changes to improve economic opportunities and access to needed health services at home (Johnston et al., 2010; Cohen, 2004).

Finally, the media depicts Mexican dentists as resisting assumptions that their services are of inferior quality because they are being provided within the global south, reframing Los Algodones as a “dental oasis” providing standardized biomedical care recognized by global citizens, and not just Mexican or American patients (Henton, 2011). In devoting media space to reinforcing this idea of Los Algodones’ as a borderlands industry town that is not quite Mexican and not quite American (Anzaldúa, 1987), the media ignores how these industry practices are still embedded within the Mexican national context and thus informed by and informing this national context as well as local and global practices on both sides of the Mexico-US border (Judkins, 2007). As Cox (1996) notes:

Globalization restructures production which undermines the power of labor in relation to capital; stimulates migrations of people in search of better working conditions and higher wages; creates an internal South in the North, and a thick layer of society [in the South] that is fully integrated into the economic North (Cox 1996: 528).

As the quote above demonstrates, the border near Los Algodones cannot be defined only geographically by the formal boundary between Mexico and the US, but must also be understood as an ideological concept that produces new movements of people and activities, and often in ways that might unevenly distribute health care and

economic resources within and across communities, countries, and regions. For example, the families of dental clinic owners working in the dental tourism industry in Los Algodones might have excellent access to expensive dental treatments; however, many residents of Los Algodones, both permanent and seasonal, might not be able to afford these treatments without the wages dental clinic owners are paid. Furthermore, many individuals might not be able to make these same journeys to the dental clinic or take up entrepreneurial opportunities in the borderlands and live instead with the losses and voids left behind from the journeys to the borderlands and the concentration of resources in places like Los Algodones. The media does not share these stories.

4.6. Conclusion

This paper analyzes American and Canadian news coverage of dental tourism activities in the northern Mexican border town of Los Algodones. We found that news media articles examined in this analysis typically focus on how practices within this industry site expands access to dental care without considering ethical concerns for this practice. The media generally ignores parallels between the dental tourism industry in Los Algodones and other industries in the area that have drawn media attention to their reliance on and perpetuation of structural injustices in their practices (Mize & Swords, 2010). The dental tourism industry relies heavily on border proximity to take advantage of the movement of people and medical equipment, much like the *maquilas* take advantage of the ability for goods to move quickly back and forth across the border (McCrossen, 2009). The industry also mimics the maquiladora industry in its use of low-wage labour to reduce costs of the manufacturing, or in this case the service, being provided (Judkins, 2007). In the context of Los Algodones' dental tourism industry, as a result of low-wage labour from many industry employees, economic benefits are primarily concentrated amongst elite tourism operators and dental patients saving money accessing dental care in Mexico (Dalstom, 2013). This concentration of economic benefits necessitates further examination than provided by the overly simplified win-win portrayal of the industry in these media reports.

By primarily relying on the voices of only two industry stakeholders (i.e., [satisfied] patients, [successful] dentists) to characterize the dental tourism industry in Los Algodones, media coverage fails to depict the industry as embedded within structural injustices that might be reinforced by industry practices. The common media

narrative discusses the town of Los Algodones but only from the perspective of the 'heroic entrepreneurs' and the 'savvy dental consumer'. The stories and histories of Los Algodones beyond the dental chair are lost to this common narrative, silencing those struggling as a result of the structural injustices that enable the industry to operate. As this paper has emphasized, the borderlands crosscut communities throughout the global north and south (Anzaldúa, 1987), separating families, concentrating resources in certain areas, and fragmenting access to health care based on differing economic contexts, whereby certain forms of dental care are made more affordable within the dental tourism industry only to those willing and able to travel for care. We argue that a more balanced and critical media portrayal of industry practices could drive a new popular discourse about medical tourism, drawing on examples from industry sites such as Los Algodones to demonstrate a need for more ethical engagement from industry stakeholders.

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Chapter 5. Drawing insights from the lived experiences of local residents and industry employees

While the previous chapter draws on my review of media sources discussing the dental tourism industry in Los Algodones, the next two analytic chapters draw on data collected during my time spent living in this Mexican medical border town. These chapters present my analysis of interviews and informal conversations with individuals living and working in Los Algodones and representing a range of roles in the industry, including dentists, dental clinic owners, marketing staff, street promoters, government officials and representatives of patient facilitation companies. These interviews highlight the perspectives of individuals not typically captured in the medical tourism literature and media sources of information. These next chapters outline and discuss what practices are actually occurring, why they are occurring, and how these practices might affect the health of different populations based on the experiences of locals residing and working in the industry. These analyses build on my examination of media discourse by providing examples drawn from the everyday lives of individuals working and living in Los Algodones to disrupt the assumptions underlying media coverage of Los Algodones' dental tourism industry.

The analysis presented in the previous chapter employs borderlands theory to examine how place shapes industry practices, drawing attention to the ways in which media discourse on Los Algodones frames the industry as occurring within a “medical mecca” or “dental oasis” conveniently located along the Mexico-US border. In chapter 6, I employ a structural exploitation and structural injustice framework to consider how and why the industry raises ethical concern and the conditions in which these concerns are borne out in reality. Specifically, this analysis disrupts assumptions regarding the accessibility of dental care within this “dental oasis” and the positive impact of the industry on the lives of local residents by highlighting more specifically for whom the industry does not enhance access to care and how the industry perpetuates structural injustices.

Chapter 7 builds on this discussion through a consideration of common discourses taken up by interview participants in Los Algodones to legitimize or justify

unjust industry practices. This analysis suggests that this discourse is taken up by industry employees in contexts of limited alternative employment options, competition for customers in the global medical tourism industry, and a profit-driven industry, highlighting the role of structural factors in shaping or enabling unjust practices in the industry.

Chapter 6.

“Stay cool, sell stuff cheap, and smile”: Examining how reputational management of dental tourism reinforces structural oppression in Los Algodones, Mexico

6.1. Introduction

“This party is for you!” the announcer shouts through the microphone while walking across the stage in front of a sign that reads: Los Algodones’ Welcome Party. A crowd of a hundred or so tourists from Canada and the United States (US) sit on white lawn chairs, enjoying free beer and tacos. The Welcome Party is one of two annual events hosted by businesses operating in the small northern border town of Los Algodones, Mexico to showcase the dental tourism industry to foreign tourists. Drawing in crowds of largely white-haired party-goers, the event is primarily open only to foreign tourists and includes dance performances, door prizes, and dental clinic employees displaying their clean and modern clinics and advanced dental technologies to potential customers who are intrigued by the promise of lower cost dental care than is available back home. While many regular winter tourists (also known as snowbirds) in the area may have already used the dental services in Los Algodones, event organizers hope the display of dental clinics and available treatment might draw customers back with the promise of world-class care at discount prices.

The Welcome Party is just one example of activities, promotional events, and marketing strategies employed by dental tourism industry members to manage Los Algodones’ reputation and protect the success of the largest employment sector in this region (Judkins, 2007). In the remainder of this paper, we draw on interviews and conversations with individuals working in Los Algodones’ dental tourism industry to examine how policies and practices related to reputational management are understood and experienced by different dental sector employees and local residents. Our analysis shows that many policies and practices related to this reputational management focus on disrupting dental tourists’ prejudiced assumptions about Mexico as a homogenously dangerous and underdeveloped country in the global south and Mexican medical care

providers as generally less knowledgeable and less capable than care providers in the global north. Employees' efforts to manage Los Algodones' reputation respond to these prejudiced assumptions about Mexico and the global south in ways that encourage and legitimize racist and classist practices. By demonstrating how industry practices follow closely the contours of global power relations, we suggest that these practices perpetuate structural injustices experienced by individual employees and residents with limited power to shape industry practices. Additionally, we argue that elite stakeholders (characterized as population groups such as the owners of large hospital chains, patient facilitation companies, and medical tourists from the global north who are well-positioned to respond to industry fluctuations by negotiating different industry practices and switching industry sites and/or care providers to meet their needs) can fail to address these structural injustices when upholding and extending unjust institutions, policies, and practices to secure their interests in the industry, raising concerns for structural exploitation in the industry.

6.2. Medical Tourism in Mexico

Medical tourism industry activity along the Mexico-US border has primarily developed in areas referred to as Mexican medical border towns. Activities typically included in these medical border towns include the provision of biomedical health services such as dental care, surgical procedures, and general medicine to patients from countries in the global north (Dalstrom, 2012; Oberle & Arreola, 2004). Canadians and Americans are known to travel abroad for medical care to save money on care typically paid for privately, for care that is unavailable, such as in the case of certain experimental procedures, and/or for care that is more desirable in terms of timeliness or type of care (Buzinde & Yarnal, 2012; Johnston et al., 2010). While the medical tourism phenomenon includes flows of patients across and throughout the global north and global south (Crush & Chikanda, 2014), in this analysis, we examine one specific flow of patients from Canada and the US to Los Algodones, Mexico for dental care, and the accompanying industry practices and employee experiences informed by this flow of patients across the Mexico-US border. Although we focus only on one type of medical tourism, namely dental tourism, our case study aims to nuance commonly cited ethical concerns for medical tourism practices in the global south that cater to patients from the global north. These concerns have typically emphasized possible health equity impacts

of medical tourism if industry development encourages care providers to work in the private sector and primarily treating foreign patients despite unmet local care needs (Snyder, 2013; Meghani, 2011). Here, we complicate and extend this discussion by drawing on structural injustice and structural exploitation frameworks to examine how industry practices might also exacerbate health inequities through the perpetuation of structural injustices.

As an industry reliant on cross-border flows of goods and services, the medical tourism industry has drawn some comparison to the Mexican maquiladora industry (Judkins, 2007). The maquiladora industry is characterized by foreign companies operating manufacturing facilities that employ workers at wages lower than what is possible in the global north (Mize & Swords, 2010). These wages enable low cost goods to flow from the maquilas to shopping centres for consumption (McCrossen, 2009), drawing parallels to the medical tourism industry in northern Mexico as patients travel to concentrations of private medical care to shop around for better deals on medical procedures (Oberle & Arreola, 2004).

Research on the lived experiences of employees working in the maquilas or manufacturing factories has prompted criticism of the maquiladora industry's reliance on and perpetuation of structural injustices including poverty and poor working conditions to guarantee good industry profits and to compete with other manufacturing sites globally (Horowitz, 2009). The global nature of the medical tourism industry also raises similar ethical concerns if elite industry stakeholders keen to protect their interest in the industry encourage poor labour conditions and other social determinants of ill health experienced by vulnerable populations desperate for work in the industry (Horowitz, 2009; Tamborini, 2007). As the medical tourism industry in Mexico seemingly relies on the provision of lower cost private medical care than available in Canada and the US to attract customers to dental tourism shopping centres (Judkins, 2007), industry sites in northern Mexico might similarly perpetuate structural injustices and structural exploitation to enhance industry profits, a concern driving our analysis below.

While academic discussion of the maquiladora industry has emphasized ethical concerns for industry practices rooted in the lived experiences of employees (Horowitz, 2009; McCrossen, 2009; Simon, 2014), empirical research on medical tourism along the northern Mexican border has predominantly examined the perspectives of medical

tourists (Miller-Thayer, 2010), the geographical distribution of medical tourism facilities (Oberle & Arreola, 2004), or the role of medical tourism facilitators in arranging foreign medical care to patients (Dalstrom, 2013a), with limited attention to the experiences and perspectives of industry employees working and living in particular industry sites. Concerns for industry practices raised in the medical tourism literature often provide broad discussions of these concerns with limited empirical analysis of realities on the ground in different industry sites (Johnston et al., 2011). For example, Buzinde & Yarnal's (2012) analysis of medical tourism practices draws on post-colonial theory to examine how neocolonial discourses in the industry might reproduce structural injustices informed by global relations of power. While this research provides important insight into how the industry might perpetuate structural injustices, this discussion does not draw on the lived experiences of different populations living and working in medical tourism industry sites, a gap we aim to address in our research.

The analysis presented herein examines the perspectives of dental tourism industry employees working in Los Algodones to nuance ethical considerations for medical tourism industry practices, particularly in contexts of vast economic asymmetries between the countries of origin for medical tourists and industry employees. While this case study provides insight relevant to other dental tourism and medical tourism sites both in northern Mexico and globally, by examining in depth one industry site catering almost entirely to dental tourists this research is able to examine structural factors informing localized industry practices. We also build upon a body of literature examining Canadian and American involvement in dental tourism (See Turner, 2008; Miller-Thayer, 2010) and consider the structural barriers to accessing dental care in these two countries as part of our analysis. These barriers are likely relevant to health systems globally (Milosevic, 2009). Before providing a discussion of our findings and analysis, we first provide an overview of the dental tourism sector in Los Algodones to demonstrate why we focus our analysis on this particular site of inquiry.

6.3. Los Algodones' Dental Tourism Sector

Los Algodones is a small town located in the state of Baja California in the northwestern region of Mexico. As a rural town previously reliant on the struggling cotton farming industry, tourism provided economic revitalization to Los Algodones in the 1980s after the town's dentist began marketing his services to tourists (Judkins, 2007). Since

this time, hundreds of dentists have established practices in Los Algodones and the population has grown from 750 to approximately 8,000 permanent residents, with an unknown number of curios (souvenir) vendors from southern Mexico residing in or near the town for part of the year (Judkins, 2007). These vendors, along with other migrant workers employed within the dental clinics, dental labs, restaurants, and liquor stores, have migrated to northern Mexico where tourist hotspots receive thousands of tourists during the winter months (Dalstrom, 2013b).

Both academic and media reports have commented on the high volume of tourists crossing the border from Yuma, Arizona to Los Algodones (estimated at up to 15,000 tourists daily during winter), suggesting that most tourists park their cars on the American side of the border and walk across the border to explore the small commercial centre and/or purchase dental services (Judkins, 2007; Henton, 2011). Along with cost savings, media sources suggest that Mexican border towns are chosen as dental tourism destinations due to their proximity to the US and existing familiarity of American and Canadian tourists with traveling to Mexico (Robbins, 2014). Los Algodones is a unique industry site in this region due to its exceptional concentration of dentists and affiliated dental services, resulting in Los Algodones' reputation in the media as a "dental oasis" (Henton, 2011) where prospective patients can choose amongst hundreds of different dental providers all within a four block radius.

The unique positioning of Los Algodones' medical tourism sector has contributed to economic development in the town and surrounding region (Oberle & Arreola, 2004; Judkins, 2007). In Los Algodones, the GDP per capita is approximately \$18,750, about 87% higher than the average GDP per capita in the rest of Mexico (Judkins, 2007). However, the specialized economic dependency of local residents on the dental tourism industry along with limited public sector investment in northern border towns raises concerns for the vulnerability of Los Algodones' residents if industry fluctuations disrupt economic stability (Oberle & Arreola, 2004; McCrossen, 2009). We consider this vulnerability of local residents in further detail below to inform our analysis of industry practices from a structural injustice and structural exploitation lens.

6.4. Methods

We employed case study methodology to examine the experiences and perspectives of industry employees in the dental tourism industry in Los Algodones. Case study methodology is well suited to exploring a phenomenon occurring within specific boundaries with the aim of generating a comprehensive and robust account of this particular phenomenon with potential relevance to similar social contexts (Gerring, 2004). Consistent with case study methodology (Flyvberg, 2006), multiple methods were used in order to understand the relevant context in addition to the on-site fieldwork reported on here that involved gathering observational and interview-based data. These methods included conducting key informant interviews with members of the Canadian dental community in order to understand the factors motivating people to access care in destinations such as Los Algodones and a detailed review of the media coverage of Los Algodones' dental sector, both of which have been reported on elsewhere (Adams et al., 2017; Adams et al., in press).

The first author (KA) traveled to Los Algodones to conduct three months of fieldwork after receiving approval from Simon Fraser University's research ethics board. KA recruited as many participants as possible during the three month fieldwork and conducted semi-structured interviews with 43 participants who held a range of roles in the dental tourism industry in Los Algodones. The majority of participants worked as dentists (n=30; 9 women, 21 men), six of whom also owned the clinics where they practice. The remainder of participants worked in the following professional roles: dental assistant (n=4; 2 women, 2 men); street promoter or patient facilitator (n=4; all men); marketing manager or business executive (n=3; 1 woman, 2 men); and municipal tourism planner (n=2; all men). It is important to note that many dentists who participated in this study also held leadership roles on tourism committees and organizations in the town; however, we have only recorded these participants' profession as dentist. Furthermore, we were not able to conduct recorded interviews with many "street promoters", those who try to chat up tourists on the street and lead them to a particular clinic for services, as they could not get permission from their employers. We also did not conduct recorded interviews with vendors given language barriers and their limited knowledge of clinic activities. However, we do draw on informal conversations with street promoters, vendors, and other residents in Los Algodones to inform our analysis.

All of the 43 interviews were recorded and lasted between 20 and 90 minutes with the majority of interviews lasting approximately 45 minutes. A semi-structured interview guide was used to generate discussion of experiences working in the clinics and/or in the dental tourism industry, perspectives on how structural factors are informing these practices, and concerns and hopes for the industry in the future. Interview recordings were transcribed verbatim, with the exception of six interviews conducted in Spanish that were transcribed and translated by a native Spanish speaker to better capture nuance in the discussion.

A thematic approach to data analysis ensued. To begin our analysis, all investigators independently reviewed six transcripts in order to identify significant themes and outliers. Next, a meeting was held to review each investigator's interpretation and to seek consensus regarding the scope and scale of the dominant themes. Through this process the analytic theme of reputational protection and management emerged as being a key aspect of industry stakeholders' concerns and actions. KA then developed a coding scheme to capture and organize the key issues informing each theme and implemented coding with the assistance of the NVivo data management program. Throughout the analytic process we enhanced rigour through employing investigator triangulation at multiple points, creating an audit trail to track key decisions and facilitating trustworthiness by triangulating observational field notes with interview data (Ryan & Bernard, 2003).

6.5. Findings

In the following section, we examine how dental employees and stakeholders intent on protecting the industry participate in activities primarily related to managing the following aspects of Los Algodones' reputation: a modern and safe tourist destination; provider of recommended or standardized care; and site for fast, lower cost dental care. We use participant quotes, and indicated the professional group of the participant who said each quote, to illustrate how these aspects of Los Algodones' reputation are managed and what this management produces in terms of industry practices and policies.

6.5.1. Los Algodones as a modern and safe tourist destination

Inside many of the clinics clustered within the town centre of Los Algodones, clinic employees can often be seen sweeping and mopping the floors throughout the day to maintain the distinctly clean appearance of the dental offices. The smell of sanitizer immediately overwhelms one's senses when stepping into clinic lobbies, along with loud broadcasts of American news stations or movies. Many clinics use the term "American" somewhere in their clinic name, and some advertise that they employ American-trained dentists. Participant discussions suggest that this sanitized and Americanized aesthetic helps distinguish Los Algodones from the dirty, unsafe Mexico imagined or expected by many tourists.

While clinic owners and employees work to sanitize and modernize their office buildings, the tourism committee and dental association in Los Algodones (both small committees predominately made up of clinic and other business owners) meet regularly to discuss possible improvements to town aesthetics to better present Los Algodones as a "modern" site with high safety standards. For example, industry employees have participated in activities such as lobbying the municipal government to pave the roads and clean up garbage on the streets. Participants suggested these activities are good for tourism because a clean, modern space might help differentiate Los Algodones from tourists' perceptions of Mexico as an underdeveloped and dangerous place. As one participant stated, "Of course this is good, because when I grew up in this town in 1969 it was a poor town, dusty town, sleepy town. The street was dusty, dusty street. Now it's another world. Tourists like to come here." (dentist)

Along with improvements to the town's aesthetics, many of the policies and activities developed by the municipal government are intended to protect tourists' safety. These policies and practices are introduced to disrupt tourists' negative stereotypes of Mexico as homogenously crime-ridden. According to one participant, the police "well, they take care of [the violence], they make sure nothing's going on in this town [...] They make sure the town is secure" (street promoter). Numerous participants referred to tourists' perceptions of Mexico as a dangerous place to justify the heavy police presence. These police officers are tasked with ensuring tourists do not witness or become victims of crime and report these experiences to the media or prospective tourists.

Informal forms of policing were used within the community to protect the reputation of Los Algodones as a safe destination. For example, one participant stated:

We want tourists to be here, we want you to spend your money. And when I say we, I am talking about everyone. In fact, if anything ever happens, when something does happen to an American or Canadian in our country, we all get pissed. Everyone (street promoter)

This quote indicates that many individuals who work and live in the town are involved in efforts to protect tourists' safety. Participants suggested that these efforts are often directed at three populations who might be perceived as threatening by tourists. The first group, street promoters, include men paid commission to encourage tourists to purchase care from particular clinics. New informal rules have been introduced that require street promoters to remain in particular areas of the town while working and to wear identification badges so tourists can file complaints about particular promoters at the tourism office. *Curios* vendors are also required to follow strict rules regarding where they can sell their products. Individuals who work in the *curios* stands are typically from the poorer regions in southern Mexico and sell souvenirs such as pottery and jewellery in spaces they rent on the sidewalks in front of dental clinics. Finally, participants indicated that a third group of street vendors, all indigenous women and children, live in or near Los Algodones and sell products such as gum, bracelets, and small wooden carvings.

Several participants raised concerns for how the indigenous population might be a tourist deterrent because individual vendors approach tourists to beg for money, stating that:

...we have to help those people [indigenous populations]. [...] we need to help them because we cannot have them in the streets because they represent our roots but sometimes they are dirty because they are not used to being clean [...] So we talked to the Mayor and the Mayor happens to be one of those people you know, from down south. So he understands the situation and so we come down and he talks to people and we do the best to avoid fights because it doesn't look good to the tourists. As long as there is money in Los Algodones for the dental work, everybody is going to have money (municipal tourism planner).

As this quote illustrates, some participants suggested that efforts to educate or police the indigenous population are legitimized by the fact that indigenous vendors represent the underdeveloped Mexico imagined by tourists. These participants suggested that the

presence of indigenous people begging for money in this industry site might disrupt attempts to distance Los Algodones from the Mexico portrayed in the media and envisioned by individuals in Canada and the US. One clinic promoter recounted a story of a dentist asking him to walk up to the roof of his clinic and dump a bucket of water on “*los indios*” (street promoter) selling souvenirs in front his clinic entrance. While rare, stories such as this one of harassment and outright violence towards vendors perceived to be hurting Los Algodones’ reputation highlight the level of concern portrayed by some participants about how vendors, and particularly indigenous vendors, might disrupt tourism and the flow of money into Los Algodones.

Along with controlling where both indigenous and non-indigenous vendors and street promoters work, elite industry members such as clinic owners and municipal government officials also keep a close watch on how vendors interact with one another. Participants often referred to competition between vendors as occasionally resulting in public altercations, raising concerns amongst elite industry stakeholders about how these altercations might confirm tourists’ fears about Mexico as a dangerous place. Participants cited activities to discourage fights amongst competing vendors, including elite industry members circulating to break up fights and reminding individuals that aggressive behaviour might deter tourists.

I tell [the vendors] ya know, stay cool, sell stuff cheap, and smile to people. [...] Don’t be aggressive to the tourists. If you be nice to them, they will give you a quarter or maybe even a dollar. Just be nice to them. And then you don’t have to push them or nothing [...] So they make their money, they make their way, they aren’t starving. Maybe down south, yes, because there is no tourism but here we are blessed by the tourism (municipal tourism planner).

As demonstrated by this quote, efforts to police the activities of vendors are legitimized by the belief that the dental sector’s current form and reputation “helps everyone gain money from the tourists” (business executive). However, by being encouraged to “keep their prices low” (municipal tourism planner) or stand only in certain locations to appease tourists, vendors and street promoters raised concerns about how these policies might affect their economic opportunities and produce more stressful work environments, particularly under the surveillance of elite industry members. Conversations with vendors and street promoters indicated that this stress is compounded by the fact that violating the informal rules of conduct might result in being “run out of town” (municipal tourism planner). Despite these concerns for their working conditions, street promoters and

vendors often described how working in the dental tourism sector is a preferable job to working in the fields, the other main industry where this population might find work.

6.5.2. Provider of high quality dental care

Participants indicated that Los Algodones' reputation as a desirable dental tourism destination relies on disrupting concerns for the quality of medical care provided in the global south. To address this concern, owners for larger clinics often employed additional staff to enhance customer service available to dental tourists, including patient coordinators who have previously lived in the US or Canada, and many paid commission to patient facilitation companies and industry related websites operating out of the global north and recommending particular industry sites and clinics to prospective dental tourists. Participants suggested that patient coordinators, facilitators, and website representatives often refer to their familiarity with dental care in the global north as helping to assure dental tourists that the quality care provided in recommended clinics meets the same standards. Given this perceived importance of clinic employees' familiarity with standards of care in Canada and the US, many clinic owners hire customer service staff who currently reside in or previously resided in the global north, limiting employment options for local residents. Furthermore, one of the most commonly cited facilitation websites operates from Ireland and arranges dental appointments for Canadians and Americans to destinations around the world. While some participants spoke positively about this website as a means of connecting global patients to clinics abroad, others felt frustrated that they were pressured to use this site to remain competitive, citing the cost of twenty British pounds per patient referral made by this website company as impacting on the profitability of their clinics.

Along with concerns about the costs of using industry related websites and facilitation companies, participants also raised concerns that many of these websites enable patients to publish seemingly unfair or inaccurate reviews, undermining efforts to manage Los Algodones' reputation as a provider of high quality care. These practices increased pressure on many clinic employees to satisfy customers, even if this means providing care that is not medically recommended. One participant explained:

Ya know we see a lot of racism. [...] We have had patients throwing money at people in the clinic, insulting people. They explode out of nowhere, and I think it is a lack of understanding how things work. And

people also trying to come here and saying, okay, it's Mexico and so you can ask for anything and I can pay you less. And it's like why? This is a medical establishment. We live with that every day. And people think, they feel superior those Americans. And I have to work around it. But it's hard. Some [tourists] will also come with, "ok this is what I want to do, this is how I want to do it, and if you won't do it, I will go to the clinic next door." And they threaten you [...] People come here and they say "okay, if you don't do this, I am going to bad mouth you everywhere. I am going to go to Facebook and TripAdvisor and I am going to bad mouth you. And just because I can." And they will openly say, you know, nobody is going to believe you, they are going to believe me (business executive).

As this quote illustrates, participants often felt pressured to accept disrespect and harassment towards Mexican employees working in the industry to satisfy customers and avoid negative online reviews. Furthermore, participants suggested that dental tourists' racist assumptions about Mexican employees encouraged patients to look for sources of information and recommendations from the global north to enhance their confidence in the care available in Los Algodones, at times resulting in a total disregard for medical opinions from Mexican dentists. One participant described how her employer recommended all clinic employees should eliminate their accents and change certain "Mexican" (marketing manager) habits that might suggest the medical care provided in Los Algodones is characteristic of care tourists might assume is provided in the country. These efforts to reduce the "Mexicanness" (marketing manager) of clinic employees exemplifies numerous efforts undertaken by industry members to reinforce tourists' perceptions that the medical care provided in Los Algodones is acceptable to foreign patients seeking high quality care.

6.5.3. Site to find fast, lower cost care

Along with safety and quality of care, participants also identified the speed and price of care as extremely important considerations for dental tourists when selecting their site of care. As a result, they have become important aspects to manage when protecting the reputation of Los Algodones' dental tourism industry. Speed of care was described as particularly important in Los Algodones because many tourists want to return across the US border at the end of the day. Participants suggested that pressure from patients to provide fast service encouraged long working hours at a very fast pace to meet expectations. One participant stated that "that's the biggest problem I have, they want to come in for a weekend and leave with a full mouth restoration" (marketing

manager), indicating that patient's expectations are at times difficult if not impossible to meet. Despite this challenge, some participants explained that their clinic owner has responded to these patient desires by adjusting the style of care to decrease the time a patient spends in the dental chair. It was also reported that the demand for trained technicians exceeds supply and so some clinics hire untrained technicians in order to increase the volume of crowns and implants that can be made in a single day and thereby provide timelier care.

Clinic owners highlighted the importance of offering competitive prices to entice tourists and to promote Los Algodones' reputation as a provider of lower-cost care. Signs out front of clinics prominently display price lists and special deals, reinforcing dental tourists' perceptions that dental care in Los Algodones is desirable because of cost savings. However, these bargain prices also raised concerns from participants about how low is too low:

That's one of the main things that is important, the prices [...] I told some patient, she was like, "how much are your teeth whitening." I was like "you know ma'am, original price \$150 but I'll give it to you for \$120 and I'll include a cleaning" and she's like, "I could have that done at home for not much more". If I would have done it for \$50, she would have come in, but \$50 that's what the whitening treatment costs me to do [...] (street promoter)

As this quote suggests, participants were often concerned about how to develop a profitable business in a competitive industry. As a result, many participants raised concerns that meeting some tourists' pricing expectations could encourage poorer quality care and/or lower wages for employees.

Participants' discussions of dental care speed and costs illuminate a key tension: the sector's reputation is based on the provision of fast, lower cost care in a safe spot, yet faster and lower cost care limits the ability of clinic employees to ensure the provision of quality care that will ultimately meet patients' desired oral health and result in positive reviews and customer loyalty. According to participants, this tension materializes when time and price constraints discourage activities such as peer-regulation, oral health promotion, and follow-up care arrangements with dental tourists' home providers. Many participants expressed concerns about how employees must work hard to navigate these tensions with limited ability to call out unfair practices by dental tourists:

It's unfair because they [potential customers] play us, they'll play three or four clinics at the same time and then you're forcing, the competitiveness is already there 'cause you are already getting a good price, but when you want to go lower than that and being unfair like that, it starts to damage [the care]. And it's already inexpensive enough and we cannot have, we cannot afford for Mexico as a country to start getting that reputation which has already got a pretty bad reputation for other things, so let's not let the medical tourism get damaged (patient facilitator).

As this quote illustrates, employees are highly aware of the competition in the global medical tourism industry and how prejudiced and negative perceptions of Mexico affect the appeal of Los Algodones within this industry.

6.6. Discussion

Interviews and informal discussions with numerous individuals working within some of the hundreds of dental clinics or in affiliated businesses such as dental labs, marketing and promotion, and street vending, show that employees in Los Algodones are concerned (and hopeful) about the future of the dental tourism sector without many alternative employment options in the region (Ruiz, 2010). As a result of this concern, employees are actively committed to protecting the industry's reputation. However, many of the perspectives we captured highlight ethically concerning practices related to managing Los Algodones' reputation, such as: the payment of low wages and/or practice of precarious employment; the presence of clinic protocols that promote long working hours and stressful working environments; the reinforcement of social hierarchies within the industry that contribute to discriminatory access to economic resources; and, finally, the perceived lack of respect for employees exemplified by threats and harassment from dental tourists. We contend that such aspects of reputational management and protection are, in fact, acting as forms of structural injustice that impact on all scales of the local dental tourism sector, from individual employees' participation in the industry to town policies meant to enhance the appeal of this industry site within the global marketplace for dental care.

In the remainder of this section, we examine our analytic findings regarding Los Algodones' dental tourism industry and the contextual factors informing unjust practices within this site. Drawing on our examples of reputational control, we demonstrate how global relations of power interconnect and coalesce in ways that differentially shape

individual experiences of the sector, including experiences of discrimination and marginalization. We demonstrate below how actors differentially access, experience, and are excluded from employment, community events, and health care based on power relations informed by race, class, and nationality. We also provide a closer examination of the idea of structural exploitation as well as an application of it to the examples offered in our examination of reputational control. By applying this theory to data grounded in the lived experiences of dental tourism employees and stakeholders, we add nuance to, and generally complicate, the ethical debates that exist regarding the global health services practice of medical tourism and the ethical considerations that inform such transnational care.

6.6.1. Protecting the industry, reproducing structural injustices

Participants' discussions of reputational management activities raise concerns for unfair and degrading labour conditions for groups whose presence and work are perceived to threaten this reputation. Examples of a dentist considering dumping buckets of water on the heads of indigenous women and elite industry members circulating to remind vendors to keep their prices low exemplify such conditions. Unjust practices directed at indigenous populations, and especially indigenous women, are particularly concerning from a social justice perspective given the well-documented marginalization of this population in Mexico. For example, indigenous women have the worst health outcomes in Mexico as a result of inequitable access to health care and other social determinants of ill health such as poverty (Pelcastre-Villafuerte et al., 2014). We argue that the practices meant to police or control indigenous vendors' activities further marginalize this population by limiting access to economic resources from tourists and by reinforcing discourses of indigenous people as a marginalized other in ways that legitimize their exclusion from community events and health care services.

Our research suggests that street promoters also experienced discrimination and harassment in their everyday interactions working in the dental tourism sector. We have documented above how perceptions that promoters lack professionalism were used to legitimize policies and practices that constitute poor working conditions such as long working hours, lower wages, and a stressful working environment. These working conditions are concerning given that the majority of promoters are deported Mexican-Americans, a population that is highly vulnerable to poor health outcomes as a result of

their deportation status and subsequent experiences of familial separation (Ojeda et al. 2011). Desperation to work anywhere but the fields is problematic as it leaves both street promoters and vendors vulnerable to industry abuse. The experiences of both of these groups in Los Algodones align with academic accounts of tourism policing practices elsewhere in Latin America that ultimately limit the wages of and security for marginalized populations reliant on the industry for their employment (Seligmann, 2014).

Even amongst 'trained' or 'professional' employees in the sector such as dentists, dental clinic owners, marketing staff, patient facilitators, and business executives, participants' experiences suggest that nationality and gender seemingly determine who counts as a trusted source of dental knowledge and, as a result, who deserves to be paid higher wages and treated with respect. As dentists vigorously sanitize their offices, Mexican marketing staff undergo training to reduce their accents, and foreign facilitation companies charge Los Algodones' dental clinics 20 British pounds per referral, these practices reinforce and are reinforced by perceptions of acceptable and standardized care provided in the global north, or at least vetted by actors residing in the global north. According to this logic, minimizing the "Mexicanness" of a clinic aesthetic or employee as a strategy of reputational protection facilitates the perception that the sector provides high quality, standardized care, conflating professionalism with practices rooted in the global north (Buzinde & Yarnal, 2012). This conflation is particularly concerning when it encourages the diversion of profits from industry employees in Mexico to individuals perceived to be more 'professional' because of their residence in the global north, as occurs in Los Algodones with patient facilitation companies. A similar diversion of profits has been documented in the literature examining the maquiladora industry in northern Mexico, reinforcing comparisons between the maquiladora and medical tourism industries in this region (McCrossen, 2009; Tamborini, 2007).

Overall, our interviews highlight common expectations or assumptions of dental tourists according to care providers and other individuals working in Los Algodones and raise concerns for the ways in which industry stakeholders might respond to these assumptions, otherwise referred to as the tourist gaze (Schantz, 2010). Dental tourism industry stakeholders' consideration of the tourist gaze highlights tensions in managing different aspects of Los Algodones' dental tourism reputation based on tourists' expectations for fast, lower cost care provided within an exotic location, but also care

which is familiar and acceptable based on patient perceptions of standardized medical care. Our research suggests that the realization of these tensions is largely informed by the commodification of health care as dental tourists look for indicators of care that is of good value, encouraging care providers to lower wages and work hard to provide services such as on-call patient coordinators and free x-rays. These responses by clinic employees are further encouraged by concerns for reputational management, particularly in contexts where new patients are looking online for indicators of good value. As a result, industry stakeholders' desires to protect and manage the reputations of Los Algodones' dental tourism industry raise concerns about medical tourism broadly in contexts where extensive efforts to manage these different aspects of reputation encourage poor working conditions characterized by discriminatory and disrespectful practices.

We believe it is important to note that dental tourists might decide to access care in Los Algodones in the face of structural barriers to accessing dental care in their home countries (Adams al., in press; Miller-Thayer, 2010). While we acknowledge the contexts of poor access to dental care that may drive dental patients abroad (Turner, 2008; Miller-Thayer, 2010), we argue that structural factors - including tourism dependence and prejudiced assumptions about the global south – might encourage tourists and elite tourism operators to perpetuate structural injustices that maintain industry practices and policies of particular benefit themselves. Many of the structural barriers pushing Canadians and Americans abroad for dental care might be unique to the dental tourism context if patients have better access to other types of care domestically (Turner, 2008); however, as we demonstrate in this analysis, the realization of unjust industry practices informed by structural factors, including those highlighted above, are not procedure specific and might occur in multiple industry sites offering a range of care while competing for customers within the global medical tourism industry.

As the announcer at the Welcome Party described at the outset of the paper subtly indicated, not everyone working and residing in Los Algodones is invited to the party. We argue that in this case, the enjoyment of the dental tourism “party” for some relies on the exclusion or degradation of others. Furthermore, drawing on our analysis of reputational protection activities in Los Algodones' dental tourism industry, we contend that this exclusion and degradation might be justified by elite industry stakeholders such as the owners of large clinics and other affiliated businesses who believe these

reputational management activities are necessary to protecting their interests in the industry.

6.6.2. Structural exploitation in medical tourism

As we showed in the previous sub-section, the dental tourism sector in Los Algodones perpetuates structural injustices experienced by individuals living and working in this area as global relations of power inform unjust industry practices, including degrading working conditions and inequitable distribution of industry resources (Mitra & Biller-Andorno, 2013; Young, 2006). We suggest that the concept of structural exploitation adds nuance to our understanding of the town's dental tourism industry and further illuminates morally problematic practices in Los Algodones. Structural exploitation differs from structural injustice in that it refers to the favouring and maintenance of unjust systems and institutions by parties who stand to gain from the perpetuation of structural injustices (Sample, 2003). Snyder (2013) suggests that the wrongfulness of structural exploitation is due to the failure of these parties to address structural injustices despite opportunities to do so through their position of power within these unjust systems or institutions.

In the case of Los Algodones' dental tourism industry, dental tourism employees generally perceived the sector to be mutually beneficial for both tourists and local employees; however, this benefit might mask what is morally problematic about the dental tourism industry in this site. We contend that if elite sector stakeholders fail to address structural injustices experienced by various employees to secure access to benefits produced by the industry, this failure is constitutive of structural exploitation. Our findings suggest that actors occupying positions of power in Los Algodones' dental tourism industry fail to address institutions, policies, and practices that reinforce and compound structural injustices. We have shown that these actors might seek to legitimize unjust practices and neglect for the needs of marginalized populations according to discourses of reputational protection while working to protect the industry and its reputation according to their own interests.

Understanding our findings from a structural exploitation perspective raises important policy considerations based on assigning responsibility to actors who perpetuate structural injustices through their role in the industry. This case study

demonstrates how industry development within particular contexts and conditions might be especially concerning from an ethical perspective as structural factors such as tourism dependence, economic asymmetries, and competition within the global medical tourism industry encourage unjust industry practices. However, as we demonstrate in our analysis, the task of assigning responsibility is complicated by the context of overlapping and interconnected structural injustices informing different individual experiences of and opportunities to shape industry practices amongst stakeholder groups living and working on both sides of the Mexico-US border. Our analysis advances key discussions of how both foreign and in-country elite actors shape medical tourism development globally (Johnston et al., 2015; Ormond, 2013; Snyder et al., 2016) and highlights the influence of global relations of power on industry practices. We suggest that multiple actors, from both destination and patient's home countries, have a role to play in reproducing, and thus ultimately alleviating, injustices pertaining to this form of tourism. This remains an important avenue for future research.

6.7. Conclusion

This case study of the dental tourism sector in one town along the northern Mexican border raises ethical concerns related to structural injustice and exploitation in the global medical tourism industry. We demonstrated how efforts to manage the reputation of this sector in Los Algodones, Mexico reinforced structural injustices based on race, class, and nationality. As we argued, events and activities related to reputational management might be supported and promoted by the vast majority of residents who are reliant on the economic gains from this type of tourism; however, even if mutually beneficial, the dental tourism “party” is not necessarily enjoyed by everyone.

In this analysis, we have suggested that discourses and practices involved in specific medical tourism contexts, particularly involving flows of patients from the global north to the global south, can reinforce and exacerbate structural injustices that maintain systems of oppression and marginalization. While our analysis relied predominantly on the voices of a few stakeholder groups (i.e., dentists and clinic owners) from one specific border town in Mexico, the narratives and experiences that emerge provide insight into the ways in which diverse populations can differentially experience practices undertaken within a single economic sector. These narratives, though partial, suggest further analysis is needed on locally contextualized medical tourism practices to examine social

justice concerns related to this industry and to begin identifying opportunities for their mitigation or elimination.

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Chapter 7.

A critical examination of empowerment discourse in medical tourism: The case of Los Algodones

7.1. Introduction

Medical tourism is a term used to describe the phenomenon of individuals intentionally traveling across national borders to privately purchase medical care (Johnston et al., 2010). Individuals might be motivated to travel as medical tourists to avoid wait lists for care and/or to access more affordable care than is domestically available or care not typically available within their domestic health care system (Johnston et al, 2010). Research on this phenomenon suggests that medical tourists travel between and within both the global north and global south; however, the majority of media and academic attention has focused on the flow of patients from the global north accessing care in the global south care that is more affordable than in their home countries (Connell, 2016; Crush & Chikanda, 2014).

Media and industry portrayals of medical tourism often suggest that this practice empowers both patients and providers to choose amongst a variety of industry sites and regulatory environments to arrange their ideal care or work experiences (Imison & Schweinsberg, 2013; Qadeer & Reddy, 2014). The industry has been portrayed in the media as a “safety zone” or “escape valve” providing alternative care options as a result of vast economic asymmetries between the global north and global south and the flexible regulatory environment in which care is provided to medical tourists (Horton & Cole, p. 1848; Whittaker & Leng, 2016). For example, media reports on the dental tourism industry in Los Algodones indicate that patients can shop around for care within a “dental oasis” of clustered care providers, enabling patients to easily try out different providers and negotiate the care and price that fits their needs (Henton, 2011). Research has also demonstrated how elite industry stakeholders including owners of large medical clinics, patient facilitation companies, and governmental bodies have encouraged the relaxation of regulatory mechanisms to enable lower cost care provision, entice medical providers keen to offer certain types of care that might not be allowed in other

jurisdictions, and ultimately increase the flow of medical tourists and profits to that particular site (Meghani, 2010; Ormond, 2011).

There are good reasons to be critical of this dominant discourse of empowerment, however. Drawing on critiques of privatization of health care encouraged by neoliberal discourses and policies (Birn, Nervi & Sequiera, 2016; Schrecker, 2016), the medical tourism literature has demonstrated how industry stakeholders have taken up neoliberal assumptions about the role of market-driven care in driving economic development and enhancing patient access to care to push forward an overly simplistic discourse of empowerment in medical tourism (Connell, 2011; Smith, 2012). For example, the alternative care options promoted in the media and industry sources of information are mostly taken up by patients from the global north and only those who are able to travel and pay for care, limiting this empowerment to a particular population which does not include the most vulnerable patients struggling to access care (Meghani, 2010). Furthermore, by presenting choice in health care as necessarily empowering (Whittaker & Leng, 2016), media coverage on medical tourism and industry discourse ignores and dismisses the myriad ways in which more choice for patients and providers can be “stressful, confusing, time consuming, and impossible to do well” (Mulligan, 2017, p. 41). Researchers suggest choice rhetoric might be taken up in media discourse and health system planning in ways that assume more choice is always good while dismissing or ignoring the unintended consequences of policies focused on enhancing patient and provider choice. These unintended consequences include new safety risks for patients when more care choices hinder effective regulatory mechanisms and/or the irresponsible use of health care resources when care provision intent on enhancing choice does not align with the health care needs in the community (Mulligan, 2017; Chanda, 2002).

Discourse emphasizing medical tourism activities as necessarily empowering care providers and other industry employees also fails to consider how the economic development opportunities promised by proponents of industry development are differentially experienced by stakeholders occupying a range of positions in the industry. Many entrepreneurial providers have struggled to guarantee profits when competing for the same pool of patients in the global medical tourism industry (Johnston et al., 2015; Snyder et al., 2016) while the relaxation of regulatory mechanisms such as licensing requirements for medical professionals and professional regulation could also enable

and exacerbate unjust practices such as low wages for industry employees and limited professional oversight to promote responsible usage of health resources (Chen & Flood, 2013; Whittaker & Leng, 2016). Overall, these critiques emphasize the potential health equity and health system implications of this empowerment discourse as it drives localized industry practices – implications that we consider and expand upon in our analysis below.

In the remainder of this article, we examine how the circulation of empowerment discourse amongst medical tourism industry stakeholders can work to mask or dismiss ethical concerns for the industry, enabling ongoing industry development. Drawing on a case study of medical tourism practices within the industry site of Los Algodones, Mexico, we provide a critical examination of how and why this empowerment discourse is taken up by industry stakeholders. We specifically argue that this discourse is taken up by industry stakeholders to promote the industry to prospective customers and investors. However, we argue that this type of promotion serves to further entrench structural injustices such as poor access to health care as this empowerment discourse assumes everyone *can* participate in the industry in ways that improve their health. We also draw on this case study to question whether providing more choice to patients is necessarily desirable for building robust health care systems if this choice involves limiting regulations needed to protect patient safety and responsible use of finite health resources. Before we examine this localized example in more detail, we first provide an overview of medical tourism industry development in Mexico and discuss why we chose Los Algodones as our site of inquiry.

7.2. Medical tourism in Los Algodones, Mexico

Los Algodones is a small town located directly across the border from Yuma, Arizona in the United States. This location has informed the development of a medical tourism industry and encouraged slow but increasing growth of the town's population. Currently, approximately 500 dentists work in Los Algodones, which is a town of 6000 residents. As a result of this concentration of dental care providers, Los Algodones has earned the title of “dental capital of the world” according to media reports (Judkins, 2007; Oberle & Arreola, 2004). This exceptional concentration of dentists has been characterised in the media and in industry marketing and promotional materials as empowering patients though increased choice for affordable and acceptable dental care

than is typically available in visitors' home care contexts (Adams et al., 2017). Dentists in Los Algodones primarily treat American and Canadian patients, many of whom are seniors who spend the winter months in Yuma as 'snowbirds'. Dental tourism in this site relies on the concentration of dental clinics available to treat tourists crossing the border for the day as well as affiliated staff and businesses including numerous labs, street promoters, patient facilitators, and medical repositories to attract customers and facilitate care provision to a high volume of patients. Generally, patients travel to Los Algodones with the intention of purchasing more affordable care than is available in their home countries; however, some tourists decide to become patients while already visiting Los Algodones to souvenir shop, enjoy the bars and restaurants, purchase lower cost alcohol or prescription drugs than available back home, or participate in community events (Miller-Thayer, 2010; Oberle & Arreola, 2004).

Los Algodones is just one of many sites in Mexico catering to medical tourists from the global north. National policies and contexts seemingly play an important role in shaping industry practices and policies in sites such as Los Algodones (Judkins, 2007; Ormond, 2011). In Mexico, the federal, state, and municipal governments have contributed substantial resources towards promoting and financially supporting tourism activities, including medical tourism (Ely, 2013). The Mexican Tourism and Convention Bureau (COTUCO) has listed medical tourism as one of twelve categories of tourism diversifications being developed and promoted in Mexico (VisitMexico.com). The state of Baja California, where Los Algodones is situated, has a webpage dedicated to advising prospective medical tourists on what to expect when traveling to the state as a medical tourist and how to choose destination cities, providers, and procedures during their medical tourism experience (Bajahealthtourism.com). Overall, the medical tourism industry in northern Mexico is portrayed on many of these government websites and promotional materials as both an important economic activity encouraging entrepreneurial pursuits as well as an opportunity to enhance patient access to desired care. As the Baja California webpage devoted to medical tourism states: "For millions, medical tourism has become the healthy choice", exemplifying how medical tourism in this context is framed as necessarily enhancing health outcomes for a large proportion of the global population (Bajahealthtourism.com). We contend that this framing seemingly ignores those who cannot participate in this "healthy choice", a concern which drives our analysis below.

7.3. Methods

We employed case study methodology to examine the dental tourism industry in Los Algodones through interviews, media reviews, and first-hand observation. Case study methodology enables a nuanced examination of a well-defined and bounded phenomenon to provide insight into complex social relations and processes (Flyvberg, 2006; Gerring, 2004). While dental tourism occurs in other northern Mexican border towns, Los Algodones is unique in that it is the only medical tourism destination site in this region focused almost entirely on dental care instead of a range of medical care options. Our case study of this unique industry site aims to trace how global forces shape local industry practices to develop a better understanding of ethical concerns for medical tourism practices grounded in the lived experiences of individuals working and residing within a particular site.

To gain insight into individuals' experiences of industry practices in Los Algodones, we recorded 43 semi-structured interviews with individuals representing a range of different professional roles including dentist (n=30; 9 women, 21 men), dental assistant (n=4; 2 women, 2 men); street promoter or patient facilitator (n=4; all men); marketing professional and business executive (n=3; 1 woman, 2 men); and municipal tourism planner (n=2; all men). Interviews were conducted during three months of observational field work in Los Algodones. I conducted all interviews in English, except for six which I conducted in Spanish. During the interviews, participants were asked about their decisions to work in the industry, descriptions of their professional role and influences on their work and industry practices, and any concerns for current industry practices and industry development. Specific questions were organized by a semi-structured guide that allowed participants to raise issues and concerns not initially probed. The recorded interviews were then transcribed verbatim and interviews conducted in Spanish were transcribed and translated to English by a native Spanish speaker for ease of analysis. Recorded interviews lasted between 20 and 90 minutes with the majority lasting approximately 45 minutes.

To analyze the data, I conducted a thematic review along with my supervisory committee of interviews and informal conversations with industry employees working in Los Algodones. All investigators independently reviewed six transcripts and we met as a team to reach consensus on significant emergent themes and the scope and scale of

each. One of the themes identified through this process was patient empowerment. The first author then developed a coding scheme to capture and organize the key issues informing this theme and then implemented coding with the assistance of the NVivo data management program. Data extracts related to patient empowerment were compiled and reviewed to identify key sub-themes and contrast them against relevant published literatures. Throughout the analytic process we enhanced rigour through employing investigator triangulation at multiple points, identifying necessary context relevant to our interpretation in order to enhance transferability, and facilitating trustworthiness by triangulating observational field notes with interview data (Ryan & Bernard, 2003).

7.4. Findings

In the remainder of this section, we share the findings from our interviews and highlight participant depictions of practices characterized as empowering for providers and patients while also drawing attention to participant concerns for various industry practices. We specifically focus on participant discussions that legitimize or justify the continuation of certain industry practices despite ethical concerns.

7.4.1. Provider (dis)empowerment

The majority of participants spoke very positively about the medical tourism industry and hoped to continue working in Los Algodones. Participants suggested that they chose to work in the industry because it afforded better working conditions than other alternatives, including wages, unique professional development, and opportunities to provide the types of care for which they were trained. Participants generally agreed that it would be very difficult to find work as a dentist in both the public and private sectors in certain regions of Mexico due to limited demand and job positions, potentially pushing dentists to seek work in the dental tourism industry. Some participants suggested that intense competition for employment in the dental sector might be caused by accepting too many dentists into dental colleges. Other participants insisted that competition for work amongst dentists is a result of structural barriers to accessing dental care in Mexico, with one participant stating: “It has to do with poverty, if you do not have money to get dressed or to eat you do not have money to go to the doctor, or to buy medicines”. This participant suggested that dentists from poorer regions of Mexico

might seek employment in other regions, including dental tourism sites, where populations can more easily pay for private medical care.

Participants suggested that dentists might be drawn to work in the industry not only for better wages but also because they preferred the working conditions and professional opportunities afforded by the industry. For example, one participant indicated that she decided to work in the dental tourism industry due to her struggle to balance work with child care. She explained that dental tourists are typically retired and are willing to book appointments during the day, unlike local residents who typically have work commitments requiring them to book appointments during evenings and weekends. Participants highlighted other pull factors for working in the industry including financial investment by government and businesses supporting medical tourism industry development. Participants suggested that this investment enabled dentists to open their own clinics with better equipment and patient support staff, as exemplified by the following quote:

Okay the situation in the late 90's, we were around 30, 40 dentists. And then the boom from the place start noise in everywhere and more people they start coming down, until the investment people or the investment in dental marketing start establish here. People who have money start opening clinics and then contract doctors. (dentist)

Because dental tourists typically access a high volume of care in a shorter amount of time compared to local residents, this has allowed dentists to treat more patients and develop their skills. Many participants explained that they prefer treating foreign patients, and almost exclusively treat non-Mexican patients, because they can provide the treatment they were trained to do, enhancing their professional development. One participant stated that: "There are two cultural levels. This is local culture, this is Mexican culture. We work by appointments, we have medical records, we have to check everything, x-ray machines and everything. They [Mexican patients] want to pull it, pull the tooth out [without proper examinations first]. Not everybody, but 90%" (dental clinic owner), suggesting that the type of care provided in the clinics catering to dental tourists is distinct from care provision in Mexico outside of the industry. Many participants also distinguished their experiences working within the medical tourism industry and outside of this industry by referring to the amount of money provided by dental clinic owners in Los Algodones to attend conferences, ongoing education, and other forms of professional development.

Despite generally positive portrayals from dentists about their work in the industry, many participants also shared stories that contradicted common assertions that the industry is necessarily characterized by professional development and desirable employment opportunities. For example, many participants explained that most dentists working in Los Algodones were not part of the local professional dental association despite professional guidelines requiring dentists to join a professional association if practicing in Mexico. While most participants did not express concerns about the limited participation in Los Algodones' professional association, referring to consumer-driven forms of regulation as encouraging acceptable quality of care, some participants raised concerns about how limited professional regulation enables unethical or unsafe dental practice. This concern was particularly focused on "some of the new entrepreneurs [who] don't want to have to pay [for professional association membership] because they want to sell their dental care for even cheaper" (dentist). Participants who raised concerns about this limited participation in the local professional association typically emphasized competition between providers as limiting communication between different medical professionals in Los Algodones, frustrating some participants who felt better collaboration at the professional association or other venues is necessary to promote high standards of care provision.

Some participants suggested that even if dentists wanted to join the professional association or other professional development activities, sometimes this is not possible due the long hours they work treating a high volume of patients. One participant explained that "The thing is, we have too many people. For example, if they sit in the chair, sometimes I don't stand up until 10:00 pm so I don't know. I don't know if this guy has two years or three years since he did the training" (dentist). Other participants expressed similar concerns that with long working hours, many dentists do not have time to join the professional organization and also cannot provide peer-regulation as there is limited opportunity to contact and communicate with dentists working in different clinics.

A few participants questioned assumptions that all dentists can access professional development opportunities to improve their skills by highlighting how some of the clinic owners do not have a dental background and as a result, might be reluctant to fund or enable dentists to attend professional development activities. This concern is exemplified by the following quote:

Yes, there are people interested in this [regulation], but nobody pays attention to us. The industry should be regulated; it would help a lot to have control over situations that are currently happening here. For example, because everything here is driven by money, people who sold blankets in stores before and now have dental clinics, they do not want to sell blankets anymore, what they do is to put a dental chair and someone to work there and now they are the owners of a clinic that is not regulated. That is why there should be regulation. (dentist)

This quote demonstrates a common perspective from dentists we interviewed that employment in the industry varies considerably between clinics, especially in terms of access to professional development opportunities and standards of care. Participants who raised a similar concern emphasized that despite the existence of high quality care in Los Algodones, there are providers who provide lower standards of care, indicating that this is made possible by the limited enforcement of regulatory standards.

7.4.2. Patient (dis)empowerment

Within a context of unique professional development opportunities and investment in high quality care provision, many participants portrayed their role in a very altruistic way and emphasized how their services expand access to desired dental care for populations facing structural barriers to accessing this care. This perception was largely informed by providers' interactions with patients who expressed high levels of gratitude for the care they had received. Multiple participants emphasized the concentration of dental clinics and affiliated services in Los Algodones as producing a type of medical marketplace for dental care that enables patients to shop around for care and select services in a clinic that best fits their needs. As one participant explained that:

Well, it's a small town, it has only two blocks actually, and you can find about 310 dental clinics, at least. And they call it "molar city", people in the United States call it "molar city" 'cause people come to get their teeth done [...] So everybody is happy here. (municipal tourism planner)

This quote exemplifies common participant perspectives that the concentration of dentists working in Los Algodones has produced a unique care context characterized by the high concentration of health human resources. Additionally, some clinic owners have hired patient coordinators and other support staff to respond to patient inquiries "around the clock", enhancing patients' ability to access care that meets their needs.

Participants suggested that the volume of online resources available to dental tourists enhances patients' access to desired care. Participants indicated that many dental tourists use online review websites to compare patient perspectives of different clinics and dental tourism industry sites in ways that informs patients of a variety of choices available to them in Los Algodones and facilitates their decision-making. Many participants also suggested that consumer-driven forms of regulation and competition for patients necessarily enhance quality of care because patient reviews online ensure "bad doctors" (dental clinic owner) go out of business. According to participants, this review system encourages dentists to provide high quality care because they know that patients can provide a negative review online and will want to avoid harming their reputation. As a result, participants suggested that some clinic owners focus on meeting customer demands through changes to their practices. These changes can include hiring untrained technicians to lower their prices, adjusting clinic practices to speed up care (i.e., one clinic has patients move from room to room in an assembly-line fashion to reduce the time dentists spend moving between offices), and hiring patient coordinators or working with facilitation companies to arrange patients' travel details and answer questions throughout their medical tourism experience.

Despite the common assertion from participants that the dental tourism industry in Los Algodones enhances patients' choices for more accessible and affordable dental care than available in their home countries, particular anecdotes and perspectives complicated this discourse by highlighting exclusionary practices in the industry and concerns for unethical and/or substandard care practices. Multiple participants questioned the effectiveness of patient review websites in driving acceptable standards of care in Los Algodones' dental tourism industry. Participants described how some patients have published inaccurate or unfair reviews when they did not like their experience. The possibility of patients publishing negative reviews online has encouraged some care providers to give treatment according to patients' demands or expectations, even if these demands do not align with safe and ethical treatment protocols. Many participants explained that dentists and other industry employees assume other employees will attract more customers by adapting or responding to patient demands, encouraging care providers to adjust to these demands, as exemplified by the following quote: "But in season they're coming from Canada or USA, so they have not much time [...] but they want all the work fast, fast, fast. And we need

to do it. Somebody will do it.” (dentist). As this quote demonstrates, providers often felt pressured to treat patients as fast as possible to attract customers keen to minimize the amount of time they need to spend in Los Algodones; however, many dentists expressed their desire for tourists to take more time so that they could provide appropriate aftercare before patients head home.

Within this competitive industry context, participants suggested that clinic employees commonly devote time and resources to providing customer service and improving online patient reviews in ways that might limit time to actually provide care to patients in need. Participants suggested that clinic employees, including dentists, often spend time reviewing x-rays and providing estimates so patients can shop around for the best price before booking their dental tourism trip. Furthermore, many dental clinics in Los Algodones advertise free x-rays and we witnessed one dental tourist undergo three x-rays in one day to compare treatment prices before determining which clinic to use. Some participants also suggested that dental tourists will sometimes get treatment fixed from a different provider at the first sign of pain, even if this care is not needed. Overall, participants suggested that patient reviews might cause dental tourists to feel overwhelmed when navigating so many different opinions, resulting in patients accessing multiple free examinations and diagnoses or other forms of unnecessary care, wasting dentists’ and other clinic employees’ time and resources.

Some participants raised concerns about exclusionary care practices in Los Algodones as many clinics focus on treating customers who will maximize profits. A few participants emphasized a large need for dental care amongst vulnerable populations living in and around Los Algodones and expressed their disappointment that many clinic owners and dentists do not use their resources to help these populations. Some dentists indicated that they provide treatment at lower cost or for free for friends, family members, or other local residents; however, participants often emphasized that local populations might only be able to access care when clinic providers are not busy treating foreign patients while some souvenir vendors said that they are never able to get the care they need in Los Algodones. Some participants explained that they don’t treat some local populations because they perceived them to be “bad patients” (dentist), characterised as patients who are late for appointments, who don’t pay in full for treatments, or request to have their teeth pulled instead of paying for recommended care. These participants suggested that they prefer treating foreign patients who pay in

full, in American dollars, and in a shortened timeframe, allowing them to generate more profit by treating a higher volume of patients who pay more for each treatment.

Finally, many participants justified their focus on treating foreign patients despite needs for dental care in the local population by explaining how local residents have existing access to dental care in the public or private sector. However, the quality of dental care provided in the public sector was commonly described by participants as “very poor” and, as a result, some of our participants felt that elite industry members could do more to enhance the oral health of local residents who cannot afford to access care within the dental tourism industry. One participant suggested that when he tried to coordinate with other clinic employees to develop a health promotion activity in local schools, no other clinic employees would work with him as they were sceptical about collaborating with a competitor and because they did not have the time to devote to this project. He explained that:

It is not common at all to find dentists who are interested in seeing local people, we are a small group of people who procure the local people, to treat them, and to charge less money for our services. Lowering our prices to serve them is difficult but I think it is possible and it can be done. I do it. (municipal tourism planner)

This participant expressed frustration with the culture of care in the dental tourism industry compared to care provision outside of the industry, explaining that: “We all are capable of providing preventive services, it is our duty as dentists to provide preventive services to the community. However, we unfortunately turn a blind eye to this situation here”. Overall, while some dentists and industry employees had developed initiatives to promote improved oral health amongst marginalized populations (i.e., one dentist uses his 3D printer to make crowns and molds for clinics in southern parts of Mexico where there are limited numbers of dental labs), multiple participants suggested these efforts were few and far between and were hard to pursue within clinic environments focused on maximizing profits.

7.5. Discussion

Participants’ discussions aligned closely with media coverage on Los Algodones’ dental tourism industry by suggesting that the context of care provision in this particular location enables international patients to access high quality dental care at more

affordable prices than typically available in Canada and the US (Adams et al., 2017). Furthermore, many participants suggested that the industry provides work opportunities for dentists struggling to secure adequate employment in the public or private sector, a perspective that is reflected in the research on the dental industry in Mexico (Gonzalez-Robledo, 2012). However, particular experiences and perspectives complicated this discourse by highlighting who is not able to access needed dental care within this industry site and how this care provision might actually exacerbate oral health inequities through irresponsible use of health resources and exclusionary care practices. Despite concerns from some participants about particular industry practices, our findings demonstrate that the profit-driven nature of the industry and competition for customers encouraged industry stakeholders to take up an overly simplistic discourse of empowerment. We argue that this discourse serves to mask and dismiss many of the concerns highlighted by participants, as we describe in further detail below.

Many participants spoke positively about consumer-driven forms of regulation of the dental tourism industry in Los Algodones, such as patient review websites, and suggested that the use of these websites by prospective dental tourists provided these patients with information to choose more desirable care options. However, some participants' stories and concerns about practices related to review websites contradicted these assertions: they expressed frustration at unfair reviews from patients who were unhappy with their care for reasons unrelated to the care itself. These examples align with findings in the literature that suggest that too much choice can be overwhelming and confusing to patients, specifically when this information is provided online (Mulligan, 2017). We found that patients sometimes sought out unnecessary treatment in Los Algodones according to recommendations from other patients via word-of-mouth or as a result of confusion when navigating contradictory advice. While the addition of care choices empowered these patients as consumers, this shift of power away from providers competing for these consumers' dollars seemingly came at a cost to patient safety and responsible use of health resources; however, this "cost" is rarely discussed by industry stakeholders focused on promoting particular industry sites such as Los Algodones.

Our findings align with research on patient review websites that indicate that within contexts of profit-driven care provision, providers often feel pressured to adjust their practice to maintain their reputation online. While this adjustment might empower

patients to find the right care provider for their needs, it also raises concerns about whether or not attention to customer satisfaction aligns with professional standards of care and ethical care provision (Menon, 2017). Our research suggests that within a profit-driven industry, dentists often felt pressured to meet patient demands and at times, this pressure encouraged unethical and/or substandard care practices characterized by unlicensed providers, limited follow-up care, and unnecessary treatment. Research examining the perspectives of doctors working in the medical tourism industry in India found that many of these doctors felt as though they could access better professional development opportunities, wages, and labour conditions by treating international patients and, as a result, were willing to go along with certain industry protocols and norms to continue working in this context (Qadeer & Reddy, 2014). Similarly, our findings suggest that dentists felt they had limited acceptable employment options outside of the industry, and as a result, they had no choice but to take up certain practices that are highly encouraged throughout the industry, including lowering their prices, speeding up their care, and focusing on treatment which meets the needs of the dental tourist population. We found that many participants were also wary about introducing regulatory measures that might increase the costs of care provision while trying to attract customers within a competitive global industry. The empowerment generated by medical tourism is thus limited for practitioners in that they may become trapped by the demands of a highly competitive industry; however, this limitation to provider choice was rarely discussed by many of our participants.

Finally, many participants ignored or dismissed concerns about unjust practices in the industry by distancing the work they perform in the medical tourism industry from health care provided within the formal health care system. Research on “border doctors” working in ‘medical border towns’ suggests that in the context of Los Algodones, care providers might perceive themselves as working in a unique space along the Mexico-US border, outside of the national health care system; as a result, they feel they do not have a responsibility to address local health needs (Horton & Cole, 2011, p. 1849). Many of our participants dismissed concerns regarding the exclusion of local populations from care provision in clinics catering to dental tourists despite oral health needs amongst local populations. This was legitimized by suggesting Mexican residents can always access care in the public sector. However, this common explanation by participants contradicts measures of oral health outcomes and access to dental care in Mexico,

which indicate that many populations struggle to access adequate dental care in contexts of poorly equipped public clinics and limited dental resources in rural areas (Gonzalez-Robledo et al., 2012). Participants' dismissal of unmet oral health needs in the local population corresponds with other research on medical tourism that suggests that many industry stakeholders perceive medical tourism activities to be a form of tourism diversification and/or entrepreneurial pursuit, distancing the work in the industry from the objectives and values regarding health equity underpinning the national health care system (Johnston et al, 2015). Thus, our research shows how industry stakeholders focused on the economic development potential of the industry might choose to focus on the empowerment experienced by some patients and providers, even though this empowerment occurs at a cost for global health equity and local access to care.

We suggest that this research nuances our understanding of how structural factors shape local medical tourism practices. As our findings show, patients are typically able to access care in the “escape valve” of Los Algodones' dental tourism industry according to global relations of power (Horton & Cole, 2011, p. 1847). Furthermore, by drawing on a discourse of empowerment which ignores these global relations of power, we contend that many stakeholders wrongly assume everyone can choose to access dental care within these alternative care spaces and that these choices necessarily enhance access to desirable care provision. In fact, pressure on industry stakeholders to compete for customers and secure employment encouraged care provision that is even more accessible and affordable to international dental tourists while further limiting access to this same care for marginalized populations. The health of marginalized populations might be negatively impacted through the irresponsible use of health resources, exclusionary care practices, and spatial injustice caused by the concentration of dentists working in Los Algodones. As care providers focus on providing faster care at lower prices while protecting their reputations in online reviews, industry employees in Los Algodones avoided treating patients who cannot pay out of pocket for care, take time off work, or travel to this specific industry site (Voigt, 2012), suggesting that this industry empowers the already empowered.

7.6. Conclusion

In the context of Los Algodones' dental tourism industry, the borderlands prove to be “quintessential spaces of exception wherein laws are regularly suspended”

(Sundberg, 2015, p. 211). As our research demonstrates, many dentists working in Los Algodones perceived themselves as “border doctors” (Horton and Cole, 2011, p. 1849) working outside of the Mexican health care system. We argue that within this discourse of exceptionalism, industry stakeholders with a vested interest in the profitability of the industry work to portray this exceptionalism as opening up new possibilities for patient empowerment; however, we raise concerns about this discourse when it is used to legitimize unethical practices within the industry. This discourse assumes that patients can choose to purchase care within this “safety zone” as a form of empowerment and those who do not are failing to take responsibility for their care (Horton & Cole, 2011; Whitaker & Leng, 2016). Furthermore, within a context of a competitive global industry, industry stakeholders might feel they actually have no choice but to participate in practices meant to promote the industry and enhance patient choice, even when these practices do not align with their values as care providers and responsible patients. Overall, this analysis demonstrates that when taking up empowerment discourse, many industry stakeholders do not consider who is (not) empowered by the industry and how this type of empowerment might exacerbate health inequities. Our case study of dental tourism in Los Algodones, Mexico suggests that industry practices and the language of empowerment used to promote the industry instead serve to trap patients and providers into practices aimed at profit maximization while widening global health inequities.

7.7. References

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Chapter 8.

Conclusion

8.1. Chapter Overview

The four analytic chapters of this dissertation have explored and described ethical concerns for medical tourism industry practices through a case study of industry activities in the small northern border town of Los Algodones, Mexico. Taken together, these chapters have responded to my research objectives, namely to: 1) identify the discourses driving dental tourism industry development in Los Algodones and analyze how these discourses are taken up and whose interests are served by these discourses; 2) describe the lived experiences of individuals interacting with the dental tourism industry in Los Algodones, highlighting the perspectives of various industry stakeholders on the impacts of the industry on their everyday lives; 3) analyze whether or not dental tourism practices operating in Los Algodones present a case of structural exploitation and identify the conditions under which this exploitation is occurring. In the remainder of this chapter, I will discuss in more detail how my analyses meet my objectives, highlighting key findings from across these analyses and situating these findings within the wider literature. I will conclude with a discussion of limitations of my research and suggestions for future research directions related to ethical examinations of and policy implications for medical tourism industry practices.

8.2. Review of dissertation objectives and key findings

Objective 1: *To identify the discourses driving dental tourism industry development in Los Algodones and analyze how these discourses are taken up and whose interests are served by these discourses*

As described in the introductory chapter, academic critiques of medical tourism have highlighted how industry sources of information have promoted the industry as a driver of economic development and source of patient empowerment with limited consideration as to who actually enjoys these benefits and at what cost to health equity (Hoffman et al., 2015; Johnston et al., 2016; Pocock & Hong Phua, 2010). Much of this critique has drawn on empirical reviews of industry sources of information, including websites, promotional materials, and newspaper articles, which suggest this information

often presents an overly positive depiction of the industry (Imison & Schweinsberg, 2013; Turner, 2011). The circulation of this discourse has raised ethical concern for how this discourse might be taken up by industry stakeholders in ways that promote and legitimize industry development despite its negative health equity implications (Crooks et al., 2011; Imison & Schweinsberg, 2013). However, there remains limited empirical research examining how industry stakeholders across multiple social positions and geographical contexts take up these discourses and how this then informs localized industry practices and ethical concerns for the industry (Carrera & Lunt, 2010; Johnston et al., 2011).

The case study presented in this dissertation responds to this first objective by looking closely at the circulation of discourses amongst various industry stakeholders to provide further insight into how and why unethical industry practices might occur. This research agrees with academic discussions for how structural factors, including structural injustices and global relations of power, can be normalized or legitimized by this circulation of discourses and serve to reinforce these structural conditions (van Dijk, 2011). These conditions, including the profit-driven nature of the industry (particularly when operating as a form of tourism diversification), economic asymmetries between industry sites and the home countries of medical tourists, and exclusionary care practices for patients who cannot participate as ideal patients in the industry, are normalized, and thus entrenched, by discourses portraying the industry as win-win for everyone involved. Throughout this dissertation, I demonstrate how the industry is portrayed this way by industry stakeholders as a form of promotion; but also, the industry is understood as a source of empowerment for patients and providers based on assumptions that more choice promotes health. My findings critique this discourse using a health equity lens and structural exploitation framework, as I outline below.

Chapters 4 and 7 provide the clearest examination and discussion of how particular discourses are shaping industry practices within Los Algodones, including practices which raise ethical concern. Chapter 4, in particular, draws on a review of Canadian and American media sources discussing the dental tourism industry in Los Algodones. This chapter argues that the assumptions presented in media discourse about medical tourism might normalize the privatization of health care and global economic asymmetries that enable the provision of lower cost care to patients from the global north. This analysis highlights how much of this discussion positions Los

Algodones as an “escape valve” (Horton & Cole, 2011, p. 1849) providing patients with more affordable and/or easily accessible care options. By framing Los Algodones’ dental tourism industry, this discourse assumes everyone can and should become savvy consumers by purchasing care in this medical marketplace. I argue in this chapter that this finding follows closely critiques of medical tourism as encouraging the privatization of health care and subsequently, exacerbating health inequities (Sengupta, 2011). However, my analysis nuances this critique by outlining how media discourses about the industry serve to reinforce the privatization of care by masking the health equity impacts of this privatization. Overall, I found that as media reports offer Los Algodones as a solution for patients struggling to find affordable care, this discourse ignores those who are not able to pay out-of-pocket for care provided through the dental tourism industry. I believe this finding provides further evidence to disrupt assumptions that the medical tourism industry necessarily expands access to care through increased patient choice and more affordable care options by highlighting the experiences of individuals living and working in an industry site.

Furthermore, my critique of discourses employed by elite industry stakeholders to promote the industry builds on critical examinations of neoliberal ideology and its impacts on health equity and social justice processes (Janes et al., 2006). This literature has highlighted how the health equity impacts of the privatization of social services can be obscured by discourses highlighting the “flexibility” of these services to adjust to the needs of different populations (Ong, 1999). The research presented in this dissertation examines how a discourse of patient empowerment is being taken up by industry stakeholders in Los Algodones and serving a similar purpose – obscuring potential health equity impacts of medical tourism practices by framing the industry as enhancing patient choice. I discuss in chapters 4 and 7 how the voices typically captured in the media and industry sources of information about Los Algodones, including the voices of dental tourists, the owners of large dental clinics, and the owners of large affiliated businesses such as facilitation companies, employed words such as “empowerment” and “choice” to present the industry as serving a positive role for everyone involved. However, my research also demonstrates that marginalized and vulnerable populations struggle to access any services as consumers with choice but limited resources. In other words, this dissertation provides a useful example of how the introduction of alternative care options via global health practices, including services provided as part of the

medical tourism industry, might actually exacerbate health inequities if these choices are taken up only by those in a privileged position to travel and pay out-of-pocket for care. Additionally, this research demonstrates that the promotion and provision of these alternative care choices might irresponsibly use finite health resources in efforts to attract customers.

The analyses presented in this dissertation also offer new insight into critical examinations of media discourse on medical tourism by disrupting common assumptions that the industry provides desirable economic development. By comparing the dental tourism industry in Los Algodones to other types of industrial activities occurring in the northern Mexican borderlands (i.e., the *maquiladora* industry), the findings from this research suggest that, like with industries operating within the borderlands, the economic benefits of the dental tourism industry are likely concentrated within the hands of elite industry stakeholders (Mize & Swords, 2008). Chapter 7 draws on interviews with a range of industry stakeholders living and working in Los Algodones to demonstrate how this border town attracts tourists, residents, and migrant workers from across the global north and global south because of the industrial activities facilitated by the proximity to the Mexico-US border. This chapter highlights how discourses touting the economic benefits of the industry are taken up and circulated by many different stakeholder groups converging in Los Algodones and economically reliant on the industry; however, by drawing on my interviews to examine why different individuals are participating in the industry, this research indicates that these discourses are likely taken up by some populations more so out of necessity (i.e., to promote the industry site and protect employment in the industry) and not because these economic benefits are perceived as desirable or adequate by all stakeholder groups.

Taken together, these analyses enhance our understanding of elite industry stakeholders as individuals well-positioned to influence discourses about the industry in ways that serve their interests. My analyses highlight how in this case, elite industry stakeholders, including the owners of patient facilitation companies and large dental clinic chains and other affiliated businesses, could use their position of power and the profits generated by this medical industry to improve access to care for marginalized populations. This conceptualization of elite industry stakeholders helps us to consider the role of medical tourists in driving industry development, including unjust industry practices. Chapter 2 of this dissertation agrees with much of the medical tourism

literature which highlights how policies and practices in medical tourists' home countries might push individuals to travel abroad for care (Kangas, 2007; Miller-Thayer, 2010). While they are in a privileged position to travel abroad for care in sites such as Los Algodones, our research indicates that dental tourists in Los Algodones often struggle to access care domestically and their decision-making might be influenced by overly positive media discourses and industry sources of information. I believe this indicates that medical tourists' decision-making is constrained by structural factors and this alleviates some of their responsibilities to address unjust industry practices in the medical tourism industry, distinguishing this population from other elite industry stakeholders. I discuss the responsibilities of different stakeholders in further detail below.

Objective 2: *To describe the lived experiences of individuals interacting with the dental tourism industry in Los Algodones, highlighting the perspectives of various industry stakeholders on the impacts of the industry on their everyday lives*

The research presented in this dissertation addresses this objective by examining the perspectives of industry stakeholders not usually described in the medical tourism literature. Much of the empirical data on medical tourism to date emphasizes the perspectives of medical tourists themselves (Kangas, 2010; Miller-Thayer, 2010), caregiver companions accompanying medical tourists on their journey (Whitmore et al., 2015), and the perspectives of health care providers and policymakers in medical tourists' departure countries (Crooks et al., 2015; Snyder et al., 2010). While empirical work has been conducted examining the perspectives of policymakers and health care providers in some destination sites for medical tourists (i.e., Ormond (2011) in Malaysia; Johnston (2016) in the Caribbean), there has been limited empirical work garnering perspectives from a range of industry stakeholders in northern Mexico. For example, previous empirical research specific to Los Algodones focused on the perspectives of medical tourists purchasing care in this small town (Miller-Thayer, 2010) or the impressions described by researchers visiting the town as tourists (Oberle & Arreola, 2004) with limited attention to the perspectives and experiences of local residents. The research presented in this dissertation offers insight into these perspectives and experiences. These insights illuminate the role of industry stakeholders not commonly considered in the medical tourism literature but potentially highly influential and/or influenced by industry development. Our research suggests that these stakeholder groups could include the heads of affiliated businesses, municipal government and

tourism planners, as well as migrant workers and marginalized local communities, groups which might be relevant to other medical tourism industry sites.

By examining the perspectives of a range of stakeholder groups, the findings of this research complicate our understanding of the industry as a source of ethical concern. Both chapters 6 and 7 highlight the perspectives and experiences of a range of industry stakeholders including street promoters, souvenir vendors and other migrant workers, and dental lab technicians, many of whom are highly marginalized populations with limited alternative economic opportunities. These participants mostly expressed gratitude for the industry as a source of economic security; however, many also pointed out frustration and/or concern about certain industry practices perceived as unfair or unjust such as low wages, harassment by clinic owners and/or dental tourists, exclusionary care, and unsafe or irresponsible care, as outlined in chapters 6 and 8. Chapter 6, in particular, provides a close examination of reputational management activities in Los Algodones. By describing why and how these activities are occurring according to various local residents and industry employees, this analysis suggests that structural factors such as economic deprivation, competition for customers between industry sites, and global relations of power inform reputational management activities intending to protect the flow of patients into the town. As described in Chapter 6, these activities seemingly limit the economic benefits from the industry available to residents in Los Algodones, exclude certain populations from accessing needed dental care, and encourage industry practices focusing on profitability instead of care provision to those in need.

While the exact roles of different industry stakeholders might not be relevant to other medical tourism industry sites, I argue that the contexts or conditions in which these unjust industry practices are occurring in Los Algodones provide important insight into the ways in which medical tourism could be ethically problematic in industry sites around the world. Many participants highlighted the failure of care providers to ensure local residents have access to needed dental care despite the concentration of dental care resources in the town and indicated that this failure is largely a result of clinic owners' desires to maximize profits within a context of economic deprivation (McCrossen, 2009). However, attempts by clinic owners and industry employees to attract customers by catering to patients' prejudiced assumptions about Mexico and desires for faster, lower cost care raise ethical concerns relevant to other industry sites

competing for the same pool of prospective medical tourists and engaging with the same marketing strategies. This finding aligns with research highlighting the competitive nature of the global medical tourism industry as producing a race-to-the-bottom effect (Snyder et al., 2016). Within this competitive environment, industry stakeholders living and working in medical tourism industry sites around the world might experience similar injustices as efforts to protect these sites drive unjust practices. As with the case of Los Algodones, migrant workers and other marginalized populations living in and around various industry sites might struggle to have their rights met when there is money to be made. This finding agrees with and nuances ethical examinations of medical tourism which have raised significant ethical concern for industry sites in the global south by highlighting how tourism dependence and economic deprivation contribute to unjust industry practices further entrenching these structural injustices.

As a type of privatized care provision, this case study adds insight into ethical concerns for the privatization of health care, particularly in contexts of global health care mobilities. While there is an extensive body of literature documenting how the provision of privately purchased medical care exacerbates health inequities due to financial barriers to accessing care (Schrecker, 2016), this research suggests that in the context of some global health care mobilities such as medical tourism, global relations of power might serve to exacerbate these health equity impacts as competition for customers drives practices informed by racism, classism, and nationalism. In this case, industry stakeholders with a vested interest in the profitability of the industry seemingly supported unjust practices that maintain their interests in the industry by limiting the role of regulatory bodies to save costs, upholding prejudiced views when hiring and training employees, and reinforcing exclusionary care practices to prioritize patients who can pay for more costly services. I argue that these activities, and many others, could have very real negative health equity impacts as these unjust practices inform social determinants of ill-health experienced by marginalized populations. These impacts could be realized both in Los Algodones and elsewhere if similar activities are taken up by elite industry stakeholders competing for medical tourists. This research suggests, however, that the health equity concerns raised in this dissertation are more likely realized in industry sites located in the global south competing for patients from the global north and facing prejudiced assumptions from customers about care provision in this context.

Finally, I believe this research emphasizes the need for current health care systems to adapt to new forms of patient mobility in ways that uphold the value of health equity. This empirical examination of medical tourism practices demonstrate how and why current regulatory frameworks might fail to mitigate unjust industry practices. In this case, the location of the industry in a tourism hotspot and within the borderlands enabled industry stakeholders to frame this site as a placeless oasis separate from the rest of Mexico and thus occurring outside of the Mexican health care system, potentially absolving industry stakeholders of a sense of responsibility to provide care to local populations. Furthermore, as industry stakeholders shopped around for the best prices and most profitable environments to set up shop, this research demonstrates how this encourages a race-to-the bottom effect with industry sites lowering standards and reducing national or local regulation needed to protect workers and health equity. With this in mind, I believe this research demonstrates the importance of developing multilateral regulatory frameworks to guide industry practices. I discuss this in further detail below when I consider future research directions.

Objective 3: *To analyze whether or not dental tourism practices operating in Los Algodones present a case of structural exploitation and identify the conditions under which this exploitation is occurring*

Chapter 6 directly responds to this objective by considering how industry employees in Los Algodones participate in reputational management activities. I argue that this participation highlights the ways in which global relations of power shape industry practices and how these relations are maintained by these practices. Based on this analysis, the industry site in Los Algodones could be considered structurally exploitative as elite industry stakeholders, in efforts to protect their interests in the industry via reputational management, exacerbate unjust relations of power and fail to address the needs of marginalized populations despite opportunities to do so. This examination aligns with the structural exploitation frameworks laid out by Snyder (2013) and Sample (2003) which assert that activities can be considered structurally exploitative when they perpetuate structural injustices to meet the interests of parties situated to benefit from these injustices. Existing structural injustices informing the development of the industry in Los Algodones include poverty, global economic asymmetries, and inequitable access to dental care, both in departure countries where financial barriers to care push dental tourists abroad (Miller-Thayer, 2010) and in Mexico where most dental care is purchased privately (Gonzalez-Robledo et al., 2012). I highlight in Chapter 6 how

concerns from certain industry stakeholders about the reputation of Los Algodones within a competitive global industry encourages these stakeholders to produce more desirable and lower cost care options for prospective customers in ways that lower wages, exclude certain populations from accessing resources and using the care provided in the industry, and divert profits to elite industry stakeholders (especially those living in the global north). This finding suggests that the structural injustices informing the industry might be perpetuated through industry practices to ensure success of the industry, and particularly success for elite industry stakeholders.

While chapter 6 provides the most direct discussion of structural exploitation in Los Algodones, all of the analyses in this dissertation contribute important insights into this ethical examination. Chapters 6 and 7 particularly illustrate how a subset of elite industry stakeholders benefit by the perpetuation of structural injustices highlighted above. Furthermore, these two chapters raise examples of how industry stakeholders including dental clinic owners could use their profits, health care resources, and proximity to highly marginalized populations living in northern Mexico to provide needed dental care. However, chapter 2 also complicates considerations of who counts as an elite industry stakeholder and responsible for the structural exploitation I witnessed in Los Algodones. By highlighting the structural factors constraining access to dental care for Canadians and Americans and pushing these populations to participate in dental tourism, this analysis questions whether these populations are actually elite stakeholders contributing to the structural exploitation outlined in chapter 6. I argue in these analyses that dental tourists purchasing care in Los Algodones likely have less responsibility than other elite industry stakeholders to address unjust industry practices given their lack of opportunity to do so; however, my research provides numerous examples of activities undertaken by dental tourists which could be changed to mitigate some of the injustices I witnessed. In particular, I argue that medical tourists could engage more ethically in medical tourism activities (particularly when traveling to industry sites with economic deprivation) by reducing pressure for faster, lower cost care.

Overall, this examination of medical tourism practices through a structural exploitation lens provides new insight into critical discussions of this practice by highlighting how this framework might capture ethical concerns which have drawn limited attention in the literature. In this case, considerations for how the industry in Los Algodones is structurally exploitative highlight how medical tourism practices could

exacerbate health inequities as a result of discriminatory or exclusionary practices and irresponsible use of resources (both medical and other resources needed for the well-being of a population). This research agrees with and builds on discussions on how global relations of power mediate the social determinants of health, including health care provision, in ways that exacerbate health inequities (Labonte et al., 2011; Shiffmen, 2015). Although the industry in Los Algodones is often portrayed in the media as benefitting all stakeholders and is seemingly supported by the vast majority of local residents as a necessary economic provider, according to my research, the industry also serves to maintain and even exacerbate relations of power based on race, nationality, and class. This finding adds to the critical global health literature by highlighting how global health practices might follow closely the contours of global relations of power as these practices are driven by and can be used to secure interests for privileged populations (Brown, 2015; Shiffmen, 2015). In particular, this research suggests that, in certain contexts, medical tourism not only expands access to care for those who can travel and pay-out-of-pocket, but also contributes to poor health for marginalized populations as the industry entrenches structural injustices.

This examination of Los Algodones' dental tourism industry through a structural exploitation lens highlights the exceptional and more common characteristics of Los Algodones, providing insight into the transferability of these research findings. First of all, as it is such a small site focused on one type of care provision, Los Algodones could be perceived as an exceptional case. My analyses also highlight highly specific concerns from many employees about drastic policy changes in Canada or the United States which could alter the insurance coverage for dental care and limit customers looking for alternative care options via the medical tourism industry. Furthermore, as a site along the borderlands, Los Algodones attracts numerous migrant workers and deported Mexican-Americans, populations who are often highly vulnerable to unemployment and industry abuses given that many are marginalized populations with limited economic opportunities (Horton & Barker, 2010). These exceptional circumstances suggest that individuals working and living in Los Algodones are highly vulnerable to industry fluctuations, raising significant concern about structural exploitation in a highly competitive global industry (Snyder et al., 2016). Individuals living in this region might feel they have no alternatives but to accept the conditions of the industry as necessary

to protecting the success of the site and the flow of customers, even in contexts of poor labour conditions and lower wages.

Despite these exceptional and highly concerning conditions in which industry development is occurring in Los Algodones, this research also highlights conditions which might be more common in other industry sites and also raise ethical concern. For industry sites not positioned within border zones or tourism hotspots, the flow of patients from the global north to global south to purchase medical care raises significant concerns from a structural exploitation perspective as this research indicates these patients might travel with prejudiced assumptions about the global south. In this case, these assumptions seemingly shaped industry practices as care providers and other industry stakeholders responded to these assumptions by positioning or adjusting their services to be acceptable to prospective dental tourists. This was often done by presenting care facilities and services as modern with Americanized aesthetics to meet the expectations of dental tourists who equate high-quality care with care aesthetics familiar in the global north. This finding aligns with critical examinations of global health practices as extending global relations of power by privileging certain aesthetics and ways of providing care (Shiffmen, 2015). In this case, this privileging of medical care aesthetics from the global north served to enhance the workload for employees working in dental clinics in Los Algodones and encouraged clinic owners to devote resources into the creation of certain aesthetics instead of the provision of care for those in need.

Taken together, the four main analytical chapters of this dissertation provide significant examples and explanations as to why I consider the industry in Los Algodones to be structurally exploitative. While individual motivations for participating in the industry are highly diverse, this research focuses on identifying the structural factors shaping industry practices and the everyday realities of individuals interacting with these practices. I believe this focus provides insight into the ways in which these structural factors are producing unjust industry practices and, when examined through a structural exploitation lens, this research provides an explanation as to why these injustices are occurring. As a result, this research serves to demonstrate how employing a structural exploitation framework to examine medical tourism practices can provide new insight into ethical concerns for medical tourism. This insight is particularly useful for critically examining the medical tourism industry in contexts of seemingly mutually beneficial industry development. Employing a structural exploitation framework, this research

suggests that industry practices can still be unjust even if mutually beneficial as elite industry stakeholders could use their position of power to mitigate negative health impacts of the industry (i.e., due to poor labour conditions) and improve the health of marginalized populations interacting with the industry.

8.3. Limitations

While I believe this research provides an in-depth examination of structural factors shaping industry practices in Los Algodones, and the subsequent ethical concerns for these practices, there are several limitations to this research. First of all, my research site of Los Algodones is confined to a small border town, limiting the ability to draw inferences from this case study about the medical tourism industry and more urban industry sites. The rurality of Los Algodones influenced the central importance of the dental tourism industry and reinforced the vulnerability of many local residents reliant on their employment within a competitive global industry. I believe this centrality of the industry informed the willingness of many participants from diverse backgrounds to speak with me and share their concerns about the future of the industry, something that might not occur in other industry sites with more diverse employment options. Furthermore, as a site located near the Mexico-US border, a border renowned for dividing the global north from the global south (McCrosen, 2009), this particular location of the industry site might limit the transferability of findings to our understanding of other sites and the medical tourism industry more broadly. For example, the location of Los Algodones near the Mexico-US border informed specific concerns I raised in this research about patients pressing to have the work completed faster and at a lower cost, particularly given the history of American and Canadian snowbirds traveling across the border to shop for items at lower costs than available in their home countries (Berger & Grant, 2010).

Additionally, by employing case study methodology, this research presents some limitations in its ability to clearly bound or delineate the “case” being studied (Nerida et al., 2014). I selected Los Algodones as a site of interest given the media attention to this location, the concentration of medical services within such a small town, and, as a Canadian researcher, the popularity of the destination for Canadians. I perceived the contextual boundary for this case to be service delivery in Los Algodones and thus considered all activities related to the delivery of dental care within the town limits to

inform my analysis. However, as I conducted my fieldwork and recruited participants, I increasingly discovered that these lines became a bit blurry. In particular, I learned about the central importance of the municipality of Mexicali in driving industry practices in Los Algodones as the mayor of Los Algodones and tourism officers are appointed by the government in Mexicali; however, numerous participants insisted that the government in Mexicali plays no role in shaping the industry in Los Algodones other than providing finances for town improvements. These ideas seemed contradictory and it became difficult to understand how to place municipal government in the sphere of influence on Los Algodones' industry. Similarly, as I increasingly learned about the role of online resources, patient facilitation companies, and other businesses in seemingly shaping patient expectations and interactions with the industry, I struggled to understand how these companies fit in this case given that none of these companies would speak with me and many had limited information about Los Algodones on their websites. In the end, the majority of my analyses describe industry practices in Los Algodones from the perspectives of local residents. While these findings speak to the influence on the industry from outside stakeholders, including patient facilitation companies, municipal and provincial government representatives, and other stakeholder groups, the perspectives of these groups could have contributed useful insight to better understand their sphere of influence.

Selection bias is also a possible limitation of this work (Roulston & Shelton, 2015). I primarily recruited participants by walking from clinic to clinic and knocking on doors. While I tried to invite participants representing various roles in the industry and from different backgrounds, doing so was limited by who was willing to speak with me and my ability to identify prospective participants. For example, I may have missed clinics located in less obvious or accessible areas. Also, receptionists at the clinic may have passed on the letter only to particular dentists or other employees such as dental clinic owners. Many of my participants who worked in clinics were owners and the vast majority of these participants were men, limiting the voices of other employees, including female employees, who may have contributed different insights into this research. I also invited participants through snowball sampling which may have limited the breadth of information or perspectives contributing to my analyses. For example, I spent considerable time living at one of the two hotels located in Los Algodones. This hotel was owned by one of the dental clinics in town and I was able to conduct interviews with

multiple different staff members for this clinic. Finally, I struggled to recruit participants outside of the clinic setting which again might have limited the range of perspectives informing this research. For example, I was only able to interview a few street promoters as many could not get permission from their bosses to participate in interviews. I also struggled to recruit patient facilitation companies who send a significant number of patients to Los Algodones.

My research is also limited by potential issues regarding rigour (Nerida et al., 2014). Although I believe I have provided a strong methodological justification and rationale for selecting Los Algodones as my case site, this research could have been strengthened by improved Spanish language skills and less time constraints for my fieldwork. While I was able to conduct interviews in Spanish, I did stumble over some terminology and struggled to develop the depth of conversation I generated when completing interviews in English. Furthermore, some participants chose to do the interview in English but also clearly struggled to convey the details they would otherwise in their native language. These language constraints might have resulted in misinterpretations from participants and myself, producing findings that do not accurately reflect the perspectives of those participants. I also relied on a Spanish speaking transcriptionist to transcribe the recorded interviews conducted in Spanish (n= 6) and this might have changed the ideas being conveyed by participants. Furthermore, the other interviews (n= 37) were all transcribed by an English speaking transcriptionist so this might have produced discrepancies in how language was captured and the inclusion of certain nuances in the recordings (Welch & Piekkari, 2006.; Marshall & While, 1994). Interestingly, most participants chose to conduct the interviews in English despite the fact that English was their second language. This might have been because they could tell that I was not fluent in Spanish. However, it might also have been because these participants were trying to present themselves as fluent in English for the purposes of maintaining the reputation of Los Algodones as an ideal industry site for American and Canadian patients. This is an important methodological consideration for research examining medical tourism within sites where common medical tourists speak a different language.

Finally, my experiences in the field also raised concerns about representation and positionality of the researcher as it impacts on the interviews and the information shared by participants. I believe that, as a woman, my gender enabled me access to

spaces that might have been restricted to a male researcher. I noticed that I was able to start numerous conversations from what started as cat-calling or mansplaining by men in Los Algodones (either dental tourists or local residents). However, in this context, my interviews were also likely shaped by gendered perceptions and it is possible that participants' answers were informed by these perceptions. I found many participants perceived me to be a journalist or undergraduate student even after explaining my role and I believe it is possible that this was a gendered reaction. While I would always reiterate my role as a doctoral student and health services researcher, these assumptions might have still shaped the type of information provided to me during the interviews and, as a result, shaped the findings informing my analysis. Finally, my positionality also informed the types of questions I asked during the interviews and the lens through which I conducted my analysis, shaping the overall focus of these analytical chapters. I have provided in-depth detail throughout my dissertation as to my methodological decision to enable readers to interpret these findings within the context of my research project (Roulston & Shelton, 2015). While I did not seek to develop generalizable findings as a qualitative researcher, when contextualized, these findings might be transferrable to other industry sites (Maxwell & Reybold, 2015).

8.4. Policy implications and future research directions

While this research is theoretical in nature and does not identify specific policy changes or program development needed to address health equity concerns for medical tourism practices, I believe the key findings across the analytical chapters of this dissertation nuance and complicate global health equity concerns for medical tourism. As highlighted in the introduction of this dissertation, these concerns have often focused on health system impacts in terms of economic gains from the industry and the impacts of the industry on health human resources available for meeting the needs of different populations (Hopkins et al., 2010; Meghani, 2011). This dissertation suggests a structural exploitation lens provides further insight into possible health equity impacts of the industry informed by metrics not typically captured in other health equity analyses. In particular, this research demonstrates how the private provision of health care can exacerbate health inequities not only because of financial barriers to accessing care for individuals but also because of the ways in which providers are practicing to compete in this global industry (i.e., clustering of clinics in tourism hotspots; exclusionary and

discriminatory care practices; the provision of the most profitable types of care; and extensive efforts marketing and promoting clinic services). These practices raise health equity concerns as this care provision might require the irresponsible use of finite health resources to attract customers while this care is available only to relatively empowered individuals who can travel to this industry site. Further research could build on these considerations by examining the realization of unjust practices in other industry sites to refine this approach and provide new insight into ways in which this framework could be used to inform health equity analyses and policy development regarding medical tourism.

This research also highlights the role of structural factors in shaping unjust medical tourism industry practices, emphasizing the need for policy implementation which addresses these factors. This dissertation sheds light on critical discussions in global health research regarding the current conceptualization of health care systems as nationally bounded (Brown, 2015). Drawing on this research, I agree with academic discussions asserting that a more cosmopolitan view of health systems could enhance fair access to resources needed for equal opportunities for good health. In particular, this cosmopolitan view could inform global health care mobilities within regulatory frameworks to distribute health resources across borders for populations most in need of care (Lencucha, 2013). While this research suggests a multilateral regulatory framework could mitigate many ethical concerns for industry practices (i.e., unjust spatial distribution of health human resources; the provision of unnecessary care; exclusionary care practices), it remains unknown what this regulation might look like and how it would inform industry practices, if at all. Further research could be done to examine how multilateral regulatory frameworks could be introduced and whose voices should shape the development of these frameworks. However, I believe the research presented in this dissertation provides useful insight into the diverse stakeholders who could play an important role in developing new forms of regulation and the critical role, and subsequent responsibilities, of elite industry stakeholders in mitigating unjust practices.

Furthermore, assigning responsibility to particular stakeholders could help to focus measures meant to mitigate the most harmful impacts of medical tourism industry practices in terms of exacerbating health inequities (Snyder et al., 2013). This research highlights the central role of structural factors in shaping unjust practices, challenging the task of actually identifying particular stakeholders most responsible for unethical industry

activities such as structural exploitation. For example, while some clinics owners in Los Algodones participated in and encouraged unjust practices, this research highlights how these decisions may have been informed by pressure to compete for customers in a competitive global industry. Despite the challenge, this research clearly highlights how elite industry stakeholders such as patient facilitation companies, government officials, and the owners of large medical clinics, have opportunities to use their positions in the industry to mitigate these harmful effects, but might choose not to protect their interests. With this in mind, this research agrees with academic discussions calling for new regulatory frameworks for the global industry (Chen & Flood, 2013). Based on my dissertation research, this regulation could focus on holding elite industry stakeholders responsible for mitigating the harmful impacts identified in this research. Furthermore, industry regulation and better education for prospective dental tourists could avoid pressure from dental tourists for lower cost and faster care, mitigating unjust practices taken up to meet dental tourists' demands.

Research on different industry sites might also provide important insights informed by different social contexts to this ethical examination. In particular, it would be interesting to consider how industry practices compare in different regional patient flows outside of North America. This would provide insight into how different governance structures and trade agreements inform these flows and the ways in which local industry sites position themselves in the global market. I believe this information could better enhance our understanding of how structural factors and institutions inform different forms of industry development around the world. This information could also highlight similarities between different industry sites in terms of unjust and structurally exploitative practices. This research could help to further identify the conditions under which medical tourism raises particular ethical concern and the role of different stakeholders in upholding these conditions, providing information needed to assign responsibility for unjust practices in medical tourism.

Finally, further research could also provide important methodological considerations for other case studies of specific industry sites, particularly in contexts of less bounded medical tourism industry sites such as medical tourism practices dispersed over a wide geographic area. This dissertation provides important insight into the value of case study methodology for ethical examinations of global health care practices given the complexity of practices involving multiple stakeholders interacting across borders

and informed by large structural factors. By focusing on a specific industry site to provide an in-depth view of industry practices, I believe this research reiterates the value of case study methodology when navigating complex phenomena with numerous stakeholders operating within overlapping policy and judicial realms. In the field of global health, case study methodology could provide a focal point for examining how large structural factors ultimately shape local health outcomes and diverse experiences with health care provision.

8.5. Concluding thoughts

As I have discussed throughout this chapter, I believe the research outlined in this dissertation provides important insight into the critical medical tourism literature and, more broadly, global health equity concerns related to global health care mobilities. This insight has drawn on ethical critiques regarding the privatization of health care and concerns about structural exploitation in cross-border, international industries to examine how emerging forms of health service provision within a globalized world might exacerbate global health inequities. By highlighting the unregulated nature of the medical tourism industry within a “dental oasis” (Henton, 2011) in the northern Mexican borderlands, this dissertation nuances our understanding of how structural factors shape global health care mobilities according to global relations of power. In other words, this research highlights how global health care mobilities such as medical tourism are both informed by and inform structural injustices. These analyses suggest that elite industry stakeholders take advantage of these injustices to promote the private provision of medical care to patients able and willing to pay, raising concerns for how these mobilities enable increased privatization of health care. Furthermore, as highlighted in this research, this privatization of care might occur uncriticised when masked by industry discourses of patient empowerment and economic development.

Overall, I believe a success of this research is its ability to highlight the value of using a structural exploitation framework to examine the medical tourism industry. By drawing on structural exploitation and structural injustice frameworks, this research serves to complicate assumptions that medical tourism industry sites are win-win for all stakeholders involved because certain industry sites are perceived as mutually beneficial. This research provides a strong counter-argument to industry and media sources of information touting the positive attributes of the medical tourism industry and

primarily informed by neoliberal ideology by outlining how, even when mutually beneficial, the industry might raise ethical concern.

8.6. References

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