Old, Broken, Disposable

Critical Discourse Analysis of the Public Health Narrative About At-Risk Populations During the COVID-19 Pandemic in Costa Rica

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ABSTRACT

During February and March, in Costa Rica, as well as in many other countries in Latin America, public health authorities and government officials insisted that there was no reason to panic or to hoard toilet paper, canned food, and disinfectants. Even though, by this time, the World Health Organization had declared that transmission of the viral infection caused by the novel coronavirus (SARS-Cov-2) had reached the level of pandemic, these health authorities and elected officials asserted that most people need not feel afraid. After all, they claimed, the disease caused by this virus appeared to be mild in most cases, that is, except in people older than 70 years of age and people with concomitant health issues such hypertension or diabetes. The purpose of this paper is to demonstrate that the epistemic authority from which the dominant narrative about COVID-19 has emerged in Costa Rica is rooted in extended and normalized discriminatory and oppressive ideologies regarding the value of people and their bodies. This official discourse is an expression of the condescending and paternalistic tradition of medical epistemology in the country. With this paper, therefore, I make a critical contribution to the exploration of the following questions. How does this narrative discourse affect older people, people with disabilities, and people who live with physical circumstances such as hypertension

or diabetes? Does this narrative discourse help the general public, fairly and in a dignify manner, to understand the risks of contagion with respect to COVID-19 and the preventative measures required to avoid the infection?

KEYWORDS
Disability, elderly, public health, necropolitics, pandemic

COVID-19 impacts the elderly and those with pre-existing health conditions most severely. In a spirit of solidarity, we all have to be ready to contribute our part to protect those people at highest risk. As individuals, practicing good hygiene and preventive measures, as well as applying social distancing and avoiding crowded places, continues to be very important.

Daniel Salas. Ministry of Health. Costa Rica.

Introduction

At the beginning of the COVID-19 pandemic, the main public message of the World Health Organization (WHO) was that the infection caused by SARS-Cov-2 affected different people differently, especially due to factors such as age and the presence of certain "pre-existing conditions" such as hypertension and diabetes. That initial pronouncement from the most relevant international health organization was promulgated by national governments, global health authorities, and the international media to the general population worldwide. In March, the Costa Rican Minister of Health, Daniel Salas, reasserted that initial message, with its underlying belief of a differential risk of mortality that could be clearly established. In an effort to avoid panic, Salas said that "in 80 percent of the population affected, the viral infection manifests as a mild flu" (Ministerio de Salud, 2020).

Given this belief about differential risk amongst a country's population, one could be led to think that the country's population can be divided into two discrete groups with regard to COVID-19: people who are at great risk of becoming seriously ill and dying of COVID-19 in one group and, in the other group, people who, in contrast, are not at great risk of becoming seriously ill and dying of this disease. Although we now know that this judgement is inexact, the rhetoric that prevailed in Costa Rica and other Latin American countries early in the pandemic relied upon this mistaken belief. As many scholars in the social sciences and humanities have discussed at length (Foucault, 2002; Austin, 1975), discourses have material consequences due to their performative power, especially in critical situations such as a pandemic. Governmental and scientific narratives determine the course of institutional actions, guiding individual behavior by persuasion or imposition. Hence, the importance of the application of critical discourse analysis to political and scientific statements. Even more important is analysis of statements which come from a source publicly recognized as an epistemic authority.

Using critical discourse theory (van Dijk, 1999), I have identified notions that have been repeated daily in official press conferences and media releases in Costa Rica. The meaning of the concepts in which I am interested has been constructed by and emerged in the official discourse through contrast with opposite concepts. This practice of differentiation has fostered a

social perception of the pandemic in dualistic terms, including perception of the oppositions between healthy and sick; responsible and irresponsible; old and young; national and foreign. The main ideas on which I shall focus my analysis are these: vulnerability, risk, old age, and pre-existing conditions. Before I consider how discourse about COVID-19 has been constructed within Costa Rica through oppositional and mutually exclusive notions, I want however to offer an overview of the scientific and medical culture in Costa Rica, which is quite similar to scientific and medical culture that exists in most Latin American countries.

Despite a few changes in the relational model between healthcare providers and patients, strong paternalism of the practice of medicine in Costa Rica still prevails. By strong paternalism, I am referring to a hierarchical and dominant model of the practice of medicine and healthcare based on the symbolic power that healthcare professionals exercise over their patients based on their epistemic privilege and authority (Cano et al., 2005). Consider, for instance, the paternalism directed at elders within Costa Rican healthcare systems. It is common for senior patients to be *infantilized*[1] in healthcare services. The autonomy, self-determination, and reflective capacity of older patients are usually disrespected or denied, often in subtle and normalized ways that are widely justified by appeal to a questionable desire to protect those who are over 65 years of age. This attitude is also common amongst family members of senior patients (with the exception of indigenous communities). Although a variety of national and international institutions, along with organizations for senior adults, have promoted important legal changes to counter these ageist attitudes, cultural change has been much more difficult to accomplish (Huenchuan-Navarro, 2004; Guillén Villegas, 2013). Nonetheless, contradictions prevail that are relevant for the subsequent analysis of institutional discourse. According to the latest report on the state of the elder population in Costa Rica, only 41 percent of older adults receive a retirement income, a percentage that is even lower when only women are counted. Furthermore, households of older adults have a higher incidence of poverty (Consejo Nacional Para la Población Adulta Mayor, 2008). The excessive paternalism towards older adults in healthcare environments – supposedly motivated by good intentions – contrasts with the exclusion and discrimination that they must face in other situations. This contradiction is evident in the discourse and public policy that the Costa Rican government's response to the pandemic have instituted.

The Costa Rican scientific and governmental discourse regarding chronic diseases – that is, "pre-existing conditions"[2] such as diabetes, hypertension, smoking, and obesity – tends to explain these health "problems" in terms of individual failures in character and behavior. Hence, national campaigns designed to raise awareness among the population about the severity of these diseases focus on the promotion of healthy habits, insisting on the high mortality rate associated with these "pathologies," leaving aside the economic, cultural, and political factors entangled in the production of health and disease.

Disabled people in Costa Rica also experience a high degree of paternalism within healthcare systems due to the healthcare provider–patient relationship model of healthcare delivery. Indeed, Costa Rican society continues to be reluctant to adopt practices to fully include the country's diversity of bodies and physical and cognitive abilities. Over the last 30 years, the disability rights movement in Costa Rica has promoted and achieved many significant legislative changes. However, as with the rights of older adults, a very large gap

exists between what the law says and what happens in real life (Campos Vargas, 2013). People with disabilities living in Costa Rica continue to experience multiple forms of discrimination and exclusion in education and employment. In healthcare settings, some practices that could even be characterized as torture continue to be perpetuated. For instance, even today, forced sterilization of girls and women with disabilities continues to be practiced in Costa Rica,[3] although it is legally prohibited. In general, the public response to disability remains influenced by a condescending tradition which does not fully advance policies that promote the emancipation and flourishing of people with disabilities (Calderón Goldenberg, 2010). Data collected by the First National Survey on Disability (INEC, 2018) indicates that 95.5 percent of people with disabilities did not receive support in their educational process – such as significant curricular accommodations, access to sign language interpreters, and psycho-pedagogy. As a result, people with disabilities have a lower level of formal education than the rest of the population, with 7.4 percent of people with disabilities living in Costa Rica having received no proper instruction at all. It should come as no surprise, therefore, that most people with disabilities living in Costa Rica live in poverty. As the survey shows, about 53 percent of people with disabilities are included in the lowest quintiles of the national ranking of family income.

Critical Discourse Analysis

As I noted at the outset of this paper, my objective is to analyze the Costa Rican governmental authorities' discourse regarding at-risk populations in the context of the current pandemic. Unlike the governments of other countries, the Government of Costa Rica announced that all public policy decisions about the pandemic were to be guided by scientific and technical criteria. The Minister of Health, Dr Daniel Salas, who is a well-known medical doctor and epidemiologist, has in this regard garnered support from various professional groups and leading scientists in the country. By analyzing the press releases and the public statements that Salas and other health authorities have made over the past five months, I have identified the main ideas at the core of the institutional and governmental discourse about the pandemic. It is relevant, first of all, to question to whom Salas is speaking. During daily press conferences, for instance, Salas addresses the public with the plural pronoun "we". Who is this "we" to which Salas refers? That is, who is included in this "we" and who is not? Given the context, I infer that this "we" does not include people who have been assigned to the category of "vulnerable" or "at-risk," as can be observed in the following quote by Dr Salas: "We all must contribute to protect the most vulnerable population against COVID-19." (Ministerio de Salud, 2020). The phrase implies that Dr Salas does not see himself as someone who should be protected. And by extension, those who are part of that "we" are not vulnerable either.

The dialogue has been established with people who are not older adults or do not understand themselves as *vulnerable* people. Although Dr Salas's repeated calls to protect the vulnerable population might seem to be an ethical and necessary choice, it is important to dig a little deeper and ask what the implications are when people whom he calls "vulnerable" do not participate as interlocutors of this dialogue. In other words, the conversation has ensued *about* this so-called vulnerable population rather than *with* this population. As a

matter of fact, to this day, Salas has not clearly and directly addressed any statements to older adults or to people with disabilities.

In his statement of March 11, Salas emphatically said that "in 80 percent of the affected population the infection manifests itself as a mild flu." One could argue that this phrasing was just based on the WHO's initial statements, that the Minister wished to merely repeat the script that had been issued by an organization recognized internationally as an epistemic authority on the subject. However, the degree of certainty with which Salas made this statement is paradoxical because, at the time that he made it, neither the WHO nor any research center in the world had sufficient scientific evidence to support the claim. During March and April, Dr Marco Boza, intensivist and official speaker of the Caja Costarricense del Seguro Social[4] (CCSS) said, on several occasions, that the disease caused by the SARS-Cov-2 was benign in 95 percent of the cases and would be fatal only for older people and people with certain "pre-existing conditions." In short, the result was that the Costa Rican population received a message from a highly respected epistemic and political authority that the pandemic was a serious and threatening event for only a very particular group of people, namely, elders and people with "pre-existing conditions." This, then, is how the official Costa Rican narrative about the pandemic was framed at its initial stage. From that moment on, this way of understanding the pandemic has played a part in several subsequent conflicts, which have worsened as the economic crisis has deepened.

In the following table, I visually present how Costa Rican authorities have conceived at-risk populations and their antitheses. The table is divided into two columns. The column on the left is entitled "Concepts mentioned in official communications". The column on the right is entitled "Opposing concepts". The first row of the table contrasts the concept of vulnerability with the concepts of invulnerability, strength, and endurance; the second row of the table contrasts the concept of risk with the concept of security; the third row of the table contrasts old age and elderly with youth; and the final row contrasts the concept of pre-existing condition with the concept of good health and no diagnosis of diabetes or high blood pressure.

Concepts mentioned in official communications	**Opposing concepts**
Vulnerability	Invulnerability, strength, endurance
Risk	Security
Old age / Elderly	Youth
Pre-existing condition	Good health, no diagnosis of diabetes or high blood pressure

This way of rationalizing the crisis has a number of very serious implications. First, this form of rationalization contributes to the de-historization of vulnerability and *vulnerabilization* of certain populations as the result of social interactions and political processes (see

Tremain, in this issue); second, this form of rationalization induces a false sense of security in those who do not see themselves as part of the so-called "vulnerable" or "at-risk" populations; and third, this form of rationalization promotes arbitrary ideas and prejudices about the stages of the life cycle, while concealing the social determinants of health.

Furthermore, this official narrative does not acknowledge the contested character of definitions of concepts such as vulnerability, risk, elderly, and pre-existing conditions. In this way, the person who embodies the maximum epistemic authority in this crisis – that is, the Minister of Health – has displayed no public interest in the wide and rich discussion regarding recent theories of disability, nor in the theoretical framework and activism against ageism, nor in the discussion about the social factors (such as gender) that influence risk perception. This authoritative indifference could thus be construed as a setback for the past gains of various social movements, including disability rights and older people's rights.

The authoritative narrative used with regard to the term *pre-existing conditions* is, essentially, a repetition of a list of pathologies, as if they were entities that exist by themselves, unrelated to people's histories and contexts and disconnected from the interaction between society and the environment. Almost every day in the press conferences that Salas holds, he mentions the words *hypertension, diabetes*, and *obesity*, suggesting that these conditions make individuals more vulnerable to the COVID-19 disease, without mentioning or even acknowledging the link between poverty and exclusion in the development of these pathologies. In this way, differences and particularities amongst people who have been diagnosed with diabetes or hypertension are erased or covered over. In essence, these people seem to get reduced to their "pre-existing conditions."

This lack of public discussion about the social production of disease has consequences. First, it legitimizes the perpetuation of a biologically reductionist approach to disease. By making the social determinants of health invisible in public discourse, the individualistic interpretation of the causes of disease prevails. People who struggle daily with hypertension, diabetes and obesity can also be victims of stigmatization when these diseases are socially perceived as to be the result of poor individual decisions, lack of discipline, and personal character. Furthermore, prejudice about old age often leads to the misconception that diabetes and hypertension are diseases associated with old age that younger people do not experience.

This individualized discourse about disease decouples power relations, structural injustice, and exclusion from health/disease outcomes and, indirectly, legitimizes the political position that places all the responsibility for managing risk on the shoulders of disadvantaged people. In other words, this narrative validates a political interpretation that releases the State from responsibility for the final outcome of the pandemic. Those who subscribe to this political position will say that, if there is an increase in the number of infected people who become ill and die, this increase is largely due to their individual behavior and respective choices. As a physician working at a public hospital told me: "This is what is happening in Costa Rica. If things go well, the government claims success, and if things go wrong, it is people's fault." In short, the government's "official" narrative, which has been sustained for several months – and legitimized by the epistemic authority of the experts which, in this case, are the response team, coordinated by the Minister of Health – may end up reinforcing ways to understand the current crisis that revictimize elders, underprivileged people living in Costa Rica, and stigmatized

people living in Costa Rica. The situation becomes even more complex as the economic crisis worsens. Given the initial discursive frame used by the government, according to which only a small group of the population is at high risk, many people now consider prevention and mitigation measures to be irrational, excessive, and harmful.

Several important pundits, as well as community and industry leaders who oppose the minimal mandatory preventive measures (such as the closure of bars and nightclubs) have argued that the economy should not suffer to this extent since COVID-19 is really serious for only a *minority* of people. In other words, these pundits and community and business leaders are using the national mortality rate (which has fluctuated between 0.5 and 0.8) to justify their demand to reopen the economy and, basically, return to "business as usual." Several opinion leaders and members of Congress have demanded, for example, that the government introduce massive testing so that people can get back to work.[5] The priority, since the beginning of this pandemic, this public health crisis, has been to protect the economy.

Old, Broken, Disposable: Governmentality during the Pandemic

In Costa Rica, exclusion and discrimination against older people with disabilities persist despite the fact that some important legal changes on these issues have been achieved. During this pandemic, the governmental and scientific discourse has (as I have indicated) associated the idea of vulnerability with an intrinsic characteristic of certain population groups. Vulnerability has not been represented and understood as an ever-changing process that results from a wide range of social interactions that take place in a given context. Furthermore, the institutional narrative in Costa Rica with respect to the pandemic and chronic diseases (high blood pressure, diabetes, obesity) has been focused on the concept of healthy lifestyle habits, placing a much greater responsibility on individual decisions than on the social determinants of health. Economic and cultural issues that determine access to food, leisure time, and others, as well as the epigenetic changes produced by structural injustice, have been left out of the public discussion of the pandemic in Costa Rica.

Government discourse on preventive and mitigation measures is focused on individual behavior: washing one's hands frequently with soap and clean water, keeping social distance, not touching one's face, using disinfectant and staying away from crowds, not visiting one's grandparents, teleworking if possible, and using delivery services. These messages, while important, completely nullify the daily life experiences of the thousands of people who are members of so-called vulnerable groups (which a certain "we" should protect) when these messages are not accompanied with analyses of systemic and structural contributors to the consequences of the pandemic. Given the fact that pre-pandemic Costa Rican society had not managed to embrace the diversity of bodies, abilities, and conditions, and furthermore given that vulnerability is not considered relevant to public discussions about how Costa Rican society should be organized, why would we expect some sort of immediate transformation of the country's social fabric to respond to this pandemic in a way that promotes inclusion and solidarity?

As the COVID-19 health crisis worsens, producing severe effects on the economy of Costa Rica, and without a comprehensive public policy that protects the common good and responds to the needs of people living in Costa Rica who have been most affected by the

pandemic, many people in Costa Rica are desperate, feeling that the only way out of this crisis is to risk their lives to put food on the table. In these critical circumstances, a false opposition between protecting people's health and protecting the country's economy seems to hold sway. Structural injustice continues to be normalized under the individualistic discourse of personal responsibility, while those who have become vulnerable due to systematic exclusion and discrimination do not get a fair chance to fight for their lives in this pandemic. Given the current scenario, it is not difficult to imagine whose bodies will be offered on the altar of "economic reactivation." To date, the Costa Rican government has not imposed any "draconian" confinement order at any time, except during Holy Week. No police repression measures or excessive fines have been carried out against people who fail to comply with the few transit restraining orders that have been put in place or with the quarantine mandate for people who have tested positive for SARS-Cov-2 and their immediate contacts. In general terms, public health measures in Costa Rica are among the most flexible in Latin America.

Although the case-fatality rate of COVID-19 in Costa Rica is one of the lowest in the Americas, COVID-19 is already the third-leading cause of death in the country (Ugarte, 2020). Yet the public health policy that the Costa Rican government has enacted to address the pandemic rests on these two pillars alone: (1) Keep the public healthcare system functioning to care for patients who require hospitalization; and (2) Trust individual responsibility to prevent contagion, i.e. wearing a mask, maintaining social distance, and avoiding crowded places. In other words, the government has opted to medicalize the pandemic, leaving aside any other strategy for mitigating or suppressing the infection. Indeed, the government's strategy is to limit restrictions on commercial activity to a minimum, making it easier for the economy to return to normal. In addition, the Costa Rican government has not implemented any plan to counteract the overwhelming misinformation surrounding the pandemic, nor has it promoted any comprehensive health-education campaign. The sole message that the authorities of the Caja Costarricense del Seguro Social (CCSS) and the Ministry of Health repeat in the media almost daily is that if people do not comply with their personal responsibilities and obligations with respect to the pandemic, then hospital services will collapse.

On several occasions, hospitals have been on the verge of collapsing, in which case it would have been necessary to apply triage guidelines. According to the bioethics protocol of the CCSS, neither age nor disability should determine access to scarce hospital resources. However, the protocol does mention the need for adequacy of the therapeutic effort based on clinical criteria and medical judgment. The CCSS guidelines do not contain any methodological advice for ensuring that the decision-making processes protect patients against prejudice and stigmatization. As I have noted, the medical culture in Costa Rica remains deeply paternalistic and thus decision-making in clinical settings depends mostly on medical discretion. For this reason, there is room for each doctor or healthcare team to enforce their own personal moral values or judgements on what quality of life really means.

One of the consequences of the medicalization of the pandemic as a public policy is reliance upon segregation and confinement as the most effective way to prevent contagion, that is, segregation and confinement of those who have been labeled as "high-risk". However, elders who are unemployed or who do not receive a retirement income and need to work for

a living cannot stay home, even if they want to do so. Since the Costa Rican government has not managed its financial resources to provide temporary support to those in need during the pandemic, many vulnerabilized people must go out to make a living. The vast majority of adults with disabilities are unemployed or have informal jobs and thus do not have any sort of social security or unemployment insurance. For these people, working from home through virtual platforms is not an alternative. Even people with disabilities who are securely employed face significant obstacles and challenges. For instance, most companies and public institutions that switched to virtual work had no policies in place to ensure the provision of necessary adaptations for their employees with disabilities. At the beginning of the pandemic, the Ministry of Education also did not have in place these sorts of policies which affected the quality of education that many students with disabilities received and many teachers with disabilities were able to provide.[6]

The Costa Rican government's decision to implement minimal state intervention in order to ensure maximum freedom for the usual economic activity is a response to the enormous pressure of economic groups and business organizations that, even from the beginning of the pandemic, actively opposed all public health strategies – such as shelter in place, quarantine, and even the mandatory use of masks – designed to mitigate or suppress contagion.

According to Franz Hinkelammert (1998), the global economic system demands human sacrifices in the name of freedom, which is claimed to be its source of legitimacy. In other words, Hinkelammert points out that the neoliberal economy demands human sacrifices in the name of freedom and in order to continue its expansion and dominance. I contend that, over the course of this pandemic, many countries have put these neoliberal ideas into practice. For example, when political authorities have called for grandparents to sacrifice themselves on behalf of their grandchildren, they demonstrate that they want to avoid the effort to adapt – even if it is a provisional adaptation – to a different economic and social pact, one that would protect all people during the pandemic, until a more effective way to deal with the virus can be put into action. Hegemonic neoliberalism works through a denial of vulnerability (Fieldman, 2011) and the culture created by this economic model produces subjectivities that despise vulnerability and, therefore, despise the work of caring for those who are vulnerable.

If we look carefully into the working conditions of workers in long-term care facilities for the elderly and for people with disabilities in Sweden, the US, Canada, and in many other countries, we will find that most of them are migrants working under exploitative conditions. (Eckenwiler, 2020). The work of caring for the most vulnerable is an undervalued job in this economic system and, therefore, is carried out by people who, themselves, are less valued. When a systemic shock occurs, Hinkelammert's political analysis tells us, the hegemonic economic system demands human sacrifices in the name of the law of the market, that is, the sacrifice of people who do not contribute to the production of wealth must be sacrificed. Achille Mbembe (2003) refers to this order of things as "necropolitics": the regime that creates worlds of death. In the context of the pandemic, these worlds of death have occurred in many cities internationally because their political authorities did not try to mitigate or suppress the contagion.[7] In these cities, there have been surges in COVID-19 cases and deaths of many people who

could have survived if the given State or local governments had implemented timely strategies to protect the people. These deaths are the result of necropolitics, whose worlds of death with respect to the pandemic have been produced by government inaction and negligence.

In Costa Rica, we have not yet seen these scenes, primarily because of the country's strong public healthcare system, considered one of the best in the world. Nevertheless, decisions of the Costa Rican government with respect to COVID-19 have revolved around the protection of the economy and the interests of economic elites, not the protection of the people. People in Costa Rica are protecting themselves as best as they can in the midst of overwhelming misinformation and confusion. As a result, the full burden of the pandemic has fallen on the public healthcare system and on healthcare professionals who are already burned out. Based on Mbembe's thesis, my argument is that high-level political decisions in Costa Rica have not been taken within a biopolitical frame, but in a necropolitical frame, despite the fact that mortality has been low. The main aim of the Costa Rican government has been to sustain *business as usual* as much as possible, while maintaining a low mortality rate at minimal political cost. The Costa Rican economic elite has demanded that public health measures must not interfere with business activity, even organizing a campaign against solidarity taxes.

The pressure to maintain "normality" as much as possible implies a denial of the crisis and, ergo, a denial of the difficulties, risks, and obstacles that the most vulnerable people must face under the current circumstances. This denial is expressed in the absence of signs of collective mourning for COVID-19 deaths. In Costa Rica, there have been no reports in the media about the people who have died of COVID-19, nor are there collective expressions of solidarity with the families who have lost a loved one due to this disease. While the death rate from COVID-19 remains low compared to other countries in the region, life seems to be returning to its "normal" course. The Ministry of Health does not provide any information about the victims, with the exception of daily reports about the number of deaths. On the Ministry of Health's website, you can find no more than the total number of deaths by province and sex. This treatment of information (or lack thereof) facilitates the depersonalization and dehumanization of the victims of the pandemic and, therefore, will facilitate a rapid collective forgetting.

As people who died due to COVID-19 go unnoticed by the community, the predominant public discourse is the demand for fewer restrictions and a full return to normality. The poorest sectors of the population have also joined this call because they are starving without government financial support. Most of these people lost their jobs in the first months of the pandemic and, for that reason, what should have been a false opposition between hunger and the risk of contagion has become a reality that made the risk of infection irrelevant. In short, the bodies most exposed to contagion and those most physically vulnerable to a severe case of the disease have been (once again) socially transformed into disposable objects. The necropolitics in this case derives from the Costa Rican government's decision to protect the neoliberal economy against social demands for redistributive justice that could have supported strategies to mitigate and suppress contagion, protecting all lives and avoiding the collapse of the public healthcare system.

Conclusion

Normality, in the Costa Rican case, is determined by the logic of neoliberal economics and exclusionary social and political practices that continue to be normalized despite constant efforts to demonstrate how violent and how harmful these practices are. In this context, to "return to normality" is to return to a social and economic order that rejects disabled bodies, rejects elders, the weak, and everyone else who is a constant reminder that we all need support to live. This pandemic has demonstrated that, under the current social and economic system, when faced with a sudden and profound crisis, society at large – including the healthcare system – will, ultimately, treat every expression of vulnerability just as it treats people with disabilities under "normal," that is, usual, daily circumstances.

NOTES

1. This is the term used in the literature, but I find it problematic, because it is pejorative.
2. The prevalence of high blood pressure in Costa Rica is 36 percent and the associated mortality has been increasing in recent years; 14.9 percent of the population has diabetes and obesity has increased significantly; 66.6 percent of people between 20 to 45 years are overweight or obese (Ministerio de Salud, 2019).
3. Personal communication in the context of my previous research on obstetric violence in Costa Rica.
4. Public healthcare system in Costa Rica
5. For instance, congresswoman María Inés Solís. See: https://www.elmundo.cr/costa-rica/maria-ines-solis-pruebas-masivas-y-a-trabajar/https://www.crhoy.com/nacionales/diputado-sugiere-pruebas-masivas-en-comunidades-por-covid-19/
6. Wilmer Rodríguez, disability advisor. Instituto Tecnológico de Costa Rica. Personal communication, October 2020.
7. Guayaquil is a terrible example of what I am referring to: https://www.washingtonpost.com/nation/2020/04/03/ecuador-coronavirus-bodies/

REFERENCES

Austin, J. (1975). *How to do things with words*. Cambridge, MA: Harvard University Press.

Calderón Goldenberg, M. (2010). El derecho al trabajo de las personas con discapaciadd en Costa Rica. Tesis Maestría en Derecho Laboral y Seguridad Social. Universida Nacional a Distancia (UNED), San José, Costa Rica.

Campos Vargas, M. (2013). La población con discapacidad en los censos del siglo XX en Costa Rica. *Población y Salud en Mesoamérica*, *11*(1), 1–43. doi 10.15517/psm.v11i1.10525

Cano, C., Gutiérrez, L., Marín, P. P., & Peláez, M. (2005). Propuesta de contenidos mínimos para los programas docentes de pregrado en Medicina Geriátrica en América Latina. *Revista Panamericana de Salud Pública*, *17*(5–6), 429–437.

Consejo Nacional Para la Población Adulta Mayor. (2008). *I informe estado de situación de la persona adulta mayor en Costa Rica*. San José: Universidad de Costa Rica.

Eckenwiler, L. (2020). A global ecological ethic for human health resources. *Bioethical Inquiry*. doi:https://doi.org/10.1007/s11673-020-10039-2

Fieldman, G. (2011). Neoliberalism, the production of vulnerability and the hobbled state. *Climate and Development*, *3*(2), 159–174.

Foucault, M. (2002). *The order of things: An archaeology of the human sciences*. London: Routledge.

Guillén Villegas, R. (2013). Abusos y malos tratos hacia personas adultas mayores: Organización Institucional de su atención. Tesis de Licenciatura en Trabajo Social. Universidad de Costa Rica, San José, Costa Rica.

Hinkelammert, F. (1998). *Sacrificios humanos y sociedad occidental: Lucifer y la Bestia*. San José: Departamento Ecuménico de Investigaciones.

Huenchuan-Navarro, S. (2004). *Marco legal y de políticas en favor de las personas mayores en América Latina*. Santiago de Chile: CEPAL.

Instituto Nacional de Estadística y Censos (INEC). (2018). *Encuesta nacional sobre discapacidad*. San José: INEC.

Mbembe, A. (2003). Necropolitics. *Public Culture*, *15*(1), 11–40.

Ministerio de Salud. (2019). *Análisis de la situación de salud*. San José: Ministerio de Salud.

Ministerio de Salud. (2020). March 20. Retrieved from https://www.ministeriodesalud.go.cr/index.php/centro-de-prensa/noticias/741-noticias-2020/1565-ministro-de-salud-daniel-salas-todos-debemos-contribuir-para-proteger-a-la-poblacion-mas-vulnerable-ante-el-covid-19

Ugarte, O. (2020). En cinco meses, CCSS aumentó en un 1000% la cantidad de camas UCI diponibles. *Semanario Universidad*, March 11. Retrieved from https://semanariouniversidad.com/pais/en-cinco-meses-ccss-aumento-en-un-1000-la-cantidad-de-camas-uci-disponibles/

van Dijk, T. (1999). El análisis crítico del discurso. *Anthropos*, *186*, 22–36.