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Shiri Noy & Koen Voorend

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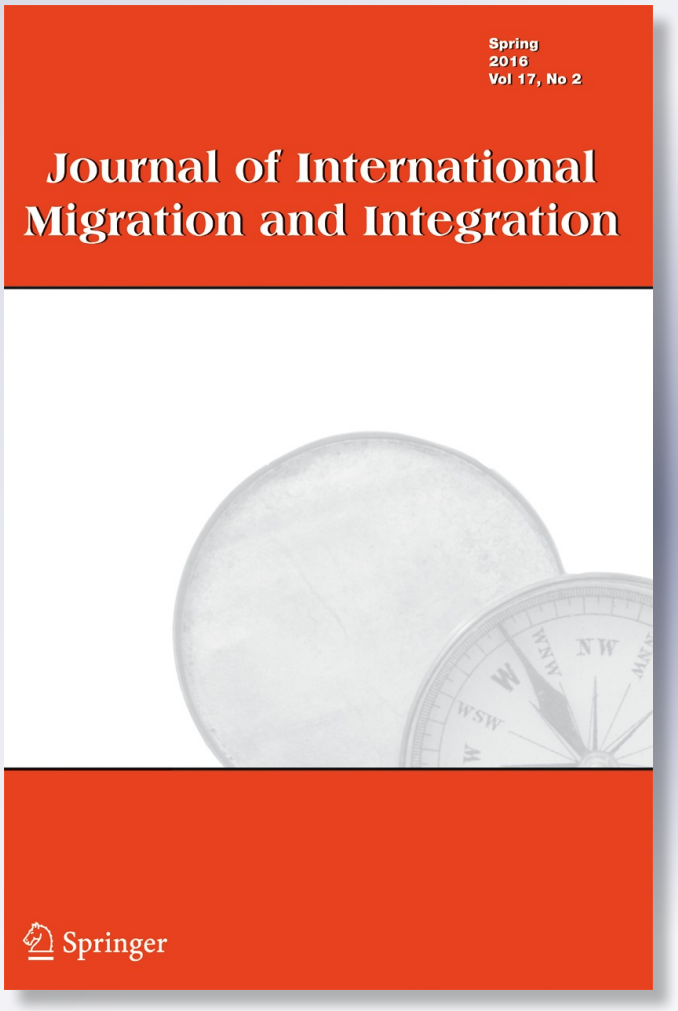

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Social Rights and Migrant Realities: Migration Policy Reform and Migrants' Access to Health Care in Costa Rica, Argentina, and Chile

Shiri Noy · Koen Voorend

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Abstract Immigration poses a significant challenge to states' existing social protection systems, especially in developing countries that are already struggling to provide social services for their citizens. In particular, immigration produces a tension between citizenship rights—those extended only to citizens, and social rights—rights extended by the state to others within their national territory. Immigration raises questions not only about the rights and access of migrants to health and other social services but also the level and quality of provisions to citizens. We draw on literatures on welfare regimes in Latin America, welfare magnets, and the legitimacy of social rights to examine the nexus of migration and health care policy in Costa Rica, Argentina, and Chile—three countries that have recently pursued immigration reform. We argue that variation in the extension of immigrants' social rights to health is explained by the interaction of existing migration and social policies, the nature of the health care system in each country, and, in some cases, international and regional norms.

Keywords Social rights · Citizenship rights · Access to health · Costa Rica · Argentina · Chile

Introduction

Latin American countries, characterized by high levels of poverty and inequality (ECLAC 2011), are not considered "welfare states" in the classic sense of the word. Unlike Western welfare states, most Latin American countries do not offer encompassing social protection systems where minimum levels of welfare are extended

S. Noy (✉)
Department of Sociology, University of Wyoming, Laramie, WY, USA
e-mail: snoy@uwyo.edu

K. Voorend
Instituto de Investigaciones Sociales, University of Costa Rica, San Pedro, Costa Rica
e-mail: koen.voorend@ucr.ac.cr

to the entire population. Nonetheless, the continent hosts some of the longest traditions of social protection in the developing world (Filgueira 1998, 2004; Huber and Stephens 2012; Mesa-Lago 1994; Noy 2011). In the wake of the debt crisis of the 1980s and neoliberal pressures of liberalization, deregulation, and privatization in the decades that followed, developing countries' social protection systems have become increasingly strained (Huber and Stephens 2012; Noy 2013a, 2013b). As a result, developing countries have struggled to extend their welfare arrangements to encompass all citizens.

Consequently, the economic and social integration of newcomers is a contested issue and raises questions about the expansion, but also the viability of maintaining existing levels, of social protection. Indeed, migration requires states to reconsider the social rights of migrants and, in the process, the rights of their citizens as well. Research on the extension of social rights for migrants is limited, though growing as researchers are increasingly turning their attention to these issues, especially in the context of developing countries. However, this scholarship seldom includes comparative perspectives in the global South and is mostly focused on how legal frameworks' recognize the social rights of immigrants, rather than the actual extension of these rights.

Existing research highlights the importance of international human rights frameworks which serve as a catalyst for governments' recognition of immigrants' social rights (Favell 2006; Garcia 2010, 2014; Jacobson 1996; Sassen 1996; Sharma 2006). While human rights are inalienable rights and entitlements based on personhood, rather than citizenship or nationality (Soysal 1994), it often falls to nation-states to protect or provide these rights. However, as part of the political exercises that define and articulate the principal mechanisms of inclusion and exclusion within societies (Fischer 2009; Mkandawire 2005), states typically conceptualize these social contracts vis-à-vis citizens, rather than with migrants or other visitors. Thus citizenship rights, those extended by states only to citizens, and social rights, those that are granted by governments to *anyone* within their territory, including migrants, do not necessarily coincide with a broader recognition of human rights (Guiraudon and Lahav 2000; Voorend 2013).

Migration adds an important dimension to our understanding of countries' social protection systems. Our comparative analysis of how immigration and health policies may be mutually constituted provides an account of the factors associated with states' different responses to and strategies for dealing with immigration. Our research contributes to the mostly European welfare literature on immigrants' rights by comparatively assessing immigrants' rights and access to health care services in Costa Rica, Argentina, and Chile. Our analysis is situated in the theoretical literature about first, welfare magnets, second, the social legitimacy of migrants' social rights, and third, welfare regimes in Latin America, and examines how these countries' health care systems and immigration policies interact to produce distinctive patterns of immigrants' social rights. In doing so, we examine how immigration, a global phenomenon, interacts with national and local institutional arrangements, and historical legacies of migration and health policy.

In the following sections, we detail our theoretical framework, after which we examine migration policy and immigrants' health rights in Costa Rica, Argentina, and Chile. We begin by outlining the structure of the health system in these three countries, characterized by comparatively generous provisions for migrants. The next section outlines recent migration policy reform efforts in these three countries. We then

turn our attention to the nexus of health care and migration policy in these countries, and focus on how immigrants' access to health care is situated in immigration reform, which has proceeded very differently across these three countries. The final section concludes by discussing the implications of our analysis and results for our understanding of the relationship between migration and health policy reforms, policy-making in the context of globalization and regionalization pressures, and for theories of welfare magnets, social legitimacy of migrants' claims, and welfare regimes.

Theoretical Framework

In the developed world, the situation of immigrants has been "largely ignored" (Sainsbury 2006, p. 230). While this statement was written nearly 10 years ago, it is still true compared to the attention given to other concerns about welfare state reform and retrenchment in developed countries. In developing countries, the literature on how immigration affects the construction of welfare regimes is even sparser (Hujo and Piper 2010), though rapidly growing. The burgeoning literature on welfare regimes in the global South (c.f. for Latin America: Filgueira 1998, 2004; Barba 2007; Martínez Franzoni 2008) has largely overlooked the migration-social policy nexus and migrants' rights and access to social policy in particular. This is surprising as South-South migration globally is almost as large as South-North migration (Hujo and Piper 2010). While Latin America and the Caribbean as a region represents low intra-regional migration with relatively few—14 % of—international migrants born in Latin America currently still residing in the region (United Nations 2012), for countries like Argentina, Costa Rica, and Chile, immigration from neighboring countries is increasing (INDEC 2010; INE 2012; INEC 2011). This trend raises important questions about migrants' integration into social policy arrangements, just as it does in the global North. In particular, because Latin American social policy arrangements have relatively long historical trajectories in the South, the experiences of Latin American countries in integrating migrants serve to inform the broader literature on South-South immigrant integration.

Welfare Magnets and Social Legitimacy of Social Policies

Historically, the nation state's consolidation has rested on the extension of social rights for its citizens, but not for outsiders—that is, the development of citizenship rights. Therefore, migrants represent a "basic challenge to the exclusionary character of the welfare state" (Rosenhek 2000, p. 49). The welfare state was, and still is, a principle means by which states gain and retain the loyalty of their populations and gain "substance by granting entitlements only to citizens" (Joppke 1999, p. 23). Broadly, both the economic and sociological literatures conceptualize immigrants as a threat to the sustainability of generous welfare states (Van Oorschot 2008). Their arguments center on two main concepts: first, the idea of states as welfare magnets, and second, immigration leading to the loss of the social legitimacy of welfare policies.

First, when the immigrant population is disproportionately dependent on social provisions (Borjas 1994; Boeri et al. 2002), or when they migrate to countries with

generous welfare states (Borjas 1998; Schram and Soss 1999; De Jong and Graefe 2002), social provisions may be considered a welfare magnet for migration. This could result in higher costs in terms of social spending, threatening the financial sustainability of welfare systems in the long run. While empirical support for such an outcome is limited (Van Oorschot 2008), in popular discourse it is common to hear echoes of the welfare magnet argument, as is the case in Costa Rica (Voorend 2013; Bonilla-Carrión 2008), Argentina (Jelin 2006; Courtis et al. 2010; Torres 2012), and Chile (Stefoni 2011). In all three countries, health care systems are viewed as representing an important pull factor for migration from neighboring, less developed countries. Migrants' demand for such services, however, is not always considered legitimate, especially if immigrants lack regular migratory status.

Second, and related, immigration can undermine the social legitimacy of a solidary and comprehensive welfare state. Immigration is typically associated with increased ethnic, linguistic, and/or racial diversity, which may undermine the sense of solidarity and homogeneous identity that form the basis for national, encompassing welfare arrangements (Freeman 1986; Van Oorschot 2008). Following resource power theory, this diversity and cultural pluralism threaten welfare states by "dividing organised labor along ethnic and linguistic lines and making it more difficult to focus politics on an agenda of economic equality as opposed to intercommunal relations and tensions" (Banting 2000, p. 18). Second, augmented awareness of differences in identity between "us" and "them" can wear down the normative consensus about welfare redistribution. Empirical evidence for this argument, however, is also limited (Banting 2000; Easterly and Levine 1997).

The Incorporation of Migrants into National Welfare Arrangements

Existing approaches are divided on the question of whether welfare states will grant migrant populations social rights (Baldwin-Edwards 2002). On the one hand, some argue that welfare states are inevitably exclusive, serving to protect their privileged citizens and that migration threatens these boundaries, resulting in countries implementing policies that limit access for migrants (Freeman 1986). Others propose that states are under pressure from international human rights discourse and agreements to grant extensive social rights to resident immigrants (Soysal 1994; Jacobson 1996; Baldwin-Edwards 2002). Human rights norms should force states to "increasingly take account of persons qua persons, rather than qua citizens [and] hence, begin to impinge on the principle of nation-based citizenship and the boundaries of the nation" (Robinson 2009, p. 22), thus overriding national attempts at exclusion.

In practice, human rights agendas are actively promoted by international multilateral institutions like the International Labor Organization (ILO) and put pressure on states to recognize and respect them through the signing of multilateral conventions. At the same time, human rights agendas can be endorsed through efforts of regional economic integration (Lucas Garín 2010a; Nwogu 2007). While a positive relationship between economic integration and human rights is not self-evident (Lucas Garín 2010a, b), regional treaties can be vehicles for the dissemination of human rights frameworks—expanding citizenship rights to social rights—as they have been in the case of

MERCOSUR (the *Mercado Común del Sur* or Southern Common market, a sub-regional trading bloc) in South America (Lucas Garín 2010a).

Furthermore, the actual level of inclusion of immigrants depends on the country-specific context and is related to each country's welfare policies as well as its immigration policies (Faist 1994; Joppke 1999; Banting 2000; Hollifield 2000; Sainsbury 2006). Traditionally, states with generous benefits and low ethnic diversity were thought to be more reluctant to grant immigrants access to benefits and transfers, preferring to preserve them for the national population (Faist 1994; Esping-Andersen 1990). However, there is little empirical evidence to support this claim (Morissens 2008; Banting 2000). Migrants appear to be better off in social-democratic welfare states, owing to the universal social policies, easier access for newcomers to citizenship or denizenship statuses, and better access to welfare benefits for immigrants (Baldwin-Edwards 2002; Van Hooren 2011; Sainsbury 2006; Hjerm 2005; Banting 2000). In contrast, more liberal welfare states demonstrate a "less inclusive" (Banting 2000, p. 23) social policy response to new minorities.

Welfare Regimes and Migration in Latin America: Costa Rica, Argentina, and Chile

Esping-Andersen's (1990) famed typology of liberal, corporatist, and social-democratic welfare states in Europe is based on the assumptions of first, a legitimized and redistributive state, and second, well developed, formal labor markets. Neither of these conditions is met in Latin American countries (Barrientos 2004; Martínez Franzoni 2008). Therefore, the term welfare regime, understood as constellations of redistributive practices across the market, the state, and the family, provides a better descriptor. In these states, social protections are extended in the context of labor markets that are unable to provide sufficient formal jobs, coupled with weak public policies (Gough and Wood 2004; Barrientos 2004).

Latin American welfare regimes are not necessarily state-led (Gough and Wood 2004) and vary in their capacity to commodify labor, decommodify welfare, and defamilialize household responsibilities (Martínez Franzoni 2008). In this article, we are primarily concerned with the state's capacity to decommodify welfare, or in other words, whether and how the provision of social protection involves the decoupling of one's welfare from one's purchasing power. The set of public interventions the state has at its disposal with the objective of preventing people suffering income and life opportunities losses, while actively promoting decent living and work conditions for all, are understood as the country's social policy regime, of which health care policy is arguably one of the most important components. Indeed, health care services play a central role in the economic and social incorporation of immigrants, and articulate one of the principle mechanisms of integration and segregation within societies, thereby becoming a political exercise that defines the institutional base of citizenship rights (Fischer 2009). Therefore, while we draw on the literature on welfare regimes, we do not focus on the commodification of labor nor the defamilialization of welfare, but rather on the decommodification of welfare. Our analysis centers on one dimension of the welfare regime literature: social policy arrangements.

The health systems of Costa Rica, Argentina, and Chile are very different, which allows the comparative leverage of examining state responses to immigration in three different health contexts. While all three have comparatively high levels of social spending, their health spending varies. Costa Rica has the highest public health spending as a percent of GDP (6.64 %) compared with Argentina (6.21 %) and Chile (4.07 %) as displayed in Table 1. Similarly, public health spending per capita is higher in Costa Rica ($345) and Argentina ($358) than in Chile ($316). More importantly, the quality of this spending varies greatly. Chile's welfare regime emphasizes labor productivity and the market management of social risks, where the state provides basic goods and services for its poorest. In Costa Rica, the state provides social services to a much larger sector of the population, including the middle class and the non-salaried population. We argue that the Argentinean state is an in-between case, which resembles Chile's more liberal regime in some ways, but has made efforts to expand its control over social policy in the last decade, for example, by nationalizing pensions and actively lobbying for the introduction of human rights and universalism in international agreements (Novick 2010).

Our case selection is further motivated by the fact that all three countries have been among the most important destination countries in Latin America over the last decade, and have significant immigrant "stocks," that is immigrants as a percentage of the total population. Costa Rica and Argentina are net migrant receivers, and while Chile is still a net migrant sending country (Cabieses et al. 2012a, b). As evident in Table 1, census data indicates a large increase in immigration over the last decade (INE 2012). Migrant stocks are at 9, 4.5, and 3 % for Costa Rica, Argentina, and Chile, respectively. Migrants currently residing in Argentina are primarily from Paraguay and Bolivia; in

Table 1 General characteristics of immigrant populations and health and social policies in Costa Rica, Argentina, and Chile

	Costa Rica	Argentina	Chile
Net migrant receiver	Yes	Yes	No
Immigrant stock	9 % (INEC 2011)	4.5 % (INDEC 2010)	3 % (INE 2012)
Migration law reform	2009/2010	2003/2004	Planned as of 2011, no implementation yet
Characteristics of the immigrant populations	Nicaragua (75 %) Colombia (4.3 %) USA (4.2 %) Panama (2.9 %) (INEC 2011)	Paraguay (36 %) Bolivia (24 %) Chile (13 %) Peru (11 %) (INDEC 2010)	Peru (30 %) Argentina (17 %) Colombia (8 %) Bolivia (7 %) Ecuador (5 %) (INE 2012)
Social policy expansion/ retrenchment	Retrenchment	Mix	Expansion but with targeting central
Public health spending as a percent of GDP	6.64 % (CEPALSTAT 2009)	6.21 % (CEPALSTAT 2009)	4.07 % (CEPALSTAT 2009)
Per capita public health spending (2005 constant dollars)	$345 (CEPALSTAT 2009)	$358 (CEPALSTAT 2009)	$316 (CEPALSTAT 2009)

Source: authors' own elaboration unless otherwise indicated

Costa Rica migrants are primarily from Nicaragua and Colombia, while Peruvians, Argentineans, and Bolivians are the largest immigrant groups in Chile (Stefoni 2008). The three countries, however, face similar challenges for immigrant integration into their social policy regimes. Finally, the governments of Costa Rica, Argentina, and Chile have recently pursued, or are in process of pursuing, immigration reform, albeit at different rates, as we detail in the following sections.

Overall, these three countries provide an important opportunity to examine how immigration reform has interacted with health policy and whether and how the delineation between citizenship rights, as compared to more inclusive social rights, has changed in recent years. More specifically, these countries provide important variation on the dimensions of interest: while all have comparatively generous health care systems, they grant differential rights to migrants, and migration reforms have further altered the landscape of migrants' social rights. Our comparative analysis allows an examination of the utility of the theoretical approaches we draw from: welfare magnets, social legitimacy, and welfare regimes for understanding migrants' integration in Latin America.

Hypotheses and Expectations

The European and North American literatures on welfare magnets, social legitimacy, and immigrants' social rights in welfare states provide useful insights, but require additional considerations if they are to be extended to the global South. First, researchers must consider the differences in the political and economic context of developing countries as compared with developed countries. It is important to distinguish between the impact of immigration on a nascent welfare state as compared to a well-established one (Morissens 2008). While in Europe the peak of migration took place during welfare states' golden age, making migrant incorporation relatively easy in these well-developed welfare states, in the South large waves of immigration took place at a time when existing welfare regimes were under significant strain in the 1980s and 1990s, a period of structural adjustment and neoliberal reforms, and pressure for cutbacks in social spending.

Second, developing states often lack the institutional capacity to regulate and effectively control labor markets, and this same institutional weakness makes it difficult to establish effective border control. Overall, external migration control tends to be much weaker than in Northern and Western Europe. Therefore, the process is less well regulated and more difficult for the state to effectively control. However, at the same time, this weaker institutional capacity makes it harder for countries in the global South to resist pressure by multilateral international agencies to adopt inclusive, human rights-focused agendas, also apparent in regional integration treaties.

Third, a significant share of immigration in the South takes place under irregular conditions (Hujo and Piper 2010), and immigrants' labor insertion is often into the informal economy. This irregular migration is likely to generate more resistance among the national population and stronger voices for welfare exclusionism, complicating states' willingness and ability to recognize migrants' social rights, and access to social protections.

Despite these differences, and in keeping with the literature on established welfare states, we expect that more integral state-led protection systems will provide better access to social resources and protections for immigrants than states with liberal, market-oriented welfare regimes. Therefore, we expect Costa Rica to provide better conditions for immigrants' integration than Argentina, which in turn would be more concerned with social integration than Chile. However, in developing country contexts where social protections do not cover the entire national population, states may be even more protective of the scarce welfare resources, resulting in higher contestation of immigrants' social integration (Baganha 2000). The social legitimacy argument contends that these same immigrants may undermine the widespread provision of social protection in these more generous welfare states. When combined with welfare magnet arguments, increased anti-immigrant sentiment may lead to the construction of nationalist boundaries around welfare benefits in Costa Rica more so than in Argentina and Chile.

Finally, given pressure from international agencies, the signing of international conventions, and regional integration initiatives, we expect human rights frameworks be manifested in recent migration reforms. This may reflect a higher tendency to legally recognize immigrant rights to social services. The legal recognition of such rights, however, does not necessarily translate to more access to health care services for migrants in practice.

Overview of Costa Rica, Argentina, and Chile's Health Systems

Costa Rica

In keeping with its generally generous social policies, Costa Rica has a public, extensive health care system. Costa Rica is hailed as a health success story of "health without wealth" (Noy 2013a), and despite its status as a developing country, it has achieved high life expectancy and low levels of infant mortality (Sáenz et al. 2011, p. S158). In 1993, Costa Rica integrated its social security program with the Ministry of Health resulting in a single-payer model managed by the social security program and financed by employers, employees, and the government with subsidies by government for the poor. The main provider of health services is Costa Rica's social security agency, the *Caja Costarricense de Seguro Social* (CCSS) established in 1941, which originally provided health services to formal workers and then expanded to include their families in 1961, but has since expanded to encompass the whole population, and effectively covers over 85 % of the Costa Rican population.

The CCSS relies on tripartite financing, from employers, employees, and the state. Only 2 % of users rely on private insurance, either through private insurers or the National Insurance Institute (*Instituto Nacional de Seguros*, INS). Therefore 15 % of the national population, consisting largely of agricultural laborers, informal sector workers, self-employed professionals, and business owners, live without public health insurance. Uninsured people however do use public health facilities, especially hospitals, despite not being officially insured (Unger et al. 2008a; Clark 2002).

Argentina

Argentina's health system is very different from Costa Rica's: as a highly decentralized country provincial governments are largely responsible for their own health policies. Broadly, the Argentinean health system is composed of three sectors: public, private, and social security (Barrientos and Lloyd-Sherlock 2000). The public sector is run by the national and provincial governments and its services are accessible to anyone requiring health care. The public system is largely utilized by people not affiliated with the social security system and those unable to afford private health care. Provincial governments work closely with public provincial hospitals, which have become increasingly financially independent since the 1990s (Barrientos and Lloyd-Sherlock 2000). The public sector is financed by public monies and is occasionally reimbursed by the social security system when its patients are attended to by public facilities, including hospitals.

The social security system is obligatory and organized along broad occupational lines or industrial sectors, and is called *Obras Sociales* (OS). There are 24 provincial *Obras Sociales* with which public employees in each province are affiliated. The other *Obras Sociales* are organized along occupational lines, created by professional associations and employee unions. Altogether, there are over 300 *Obras Sociales*, which have their root in health insurance funds for workers created by trade unions (Belmartino 2000). In 1970, the *Obras Sociales* system was institutionalized with the passing of Law 18.610 which made employee contribution mandatory. There is a separate institute for pensioners, the *Programa de Atención Médico Integral* (PAMI) administered by the National Institute for Social Services for Retirees and Pensioners (*Instituto Nacional de Servicios Sociales para Jubilados y Pensionados*, INSSJP) which is its own OS. PAMI and the *Obras Sociales* together cover slightly less than half of the Argentinean population (Belló and Becerril-Montekio 2011). The private sector consists of clinics and facilities that service OS affiliates following from agreements between these affiliates and the OS and private insurance plans (called *Empresas de Medicina Prepaga*, EMP or "prepagas") that can be paid by individuals or companies with resources negotiated with the OS.

Chile

Chile's health system, like Argentina's, is decentralized along the country's 15 regions and 351 municipalities. Municipalities are responsible for public primary health care and work closely with public hospitals under their jurisdiction. Some services are universal under the public system, though usage varies by socioeconomic status (Cabieses et al. 2012a). Social provision in Chile has undergone large-scale changes since the 1980s. Chile's health system is particularly is well known for its neoliberal reforms during the dictatorship of Augusto Pinochet, heavily influenced by foreign consultants and international financial institutions (Unger et al. 2008b). Until the 1980s, there was only the public system, which had been created in 1952. In 1981, under Pinochet, a private health insurance system, *Instituciones de Salud Previsional* (ISAPRE), was established in an effort to complement the existing public system. The goal was for the private ISAPRE system to serve as the dominant health provider in

the country. In 1979, the National Health Fund (*Fondo Nacional de Salud*, FONASA) was established to oversee the public system.

Those living below the national poverty line have access to public services free of charge, where others can utilize public services with a co-pay determined by their household income. They can also, however, utilize the ISAPRES insurance system, which has over 2,500 different schemes available (Cabieses et al. 2012b). Only 12 % of the population utilizes ISAPRES which, coupled with comparatively low government expenditures, has created strain on the public health resources. In 2005, a new health plan, the System of Health Guarantees Law (*Plan de Acceso Universal de Garantías Explícitas*, Plan AUGE) was implemented in Chile. It ensures minimum coverage for particular diseases under the ISAPRES and created measures attempting to reduce waiting times and improve the quality of the public health sector. This plan was intended to address issues of equity and inequality in the Chilean system, in particular between the private and public sectors (Cabieses et al. 2012a).

In the following section, we detail the history of contemporary migration policies, the paradigms underpinning their logics, and migration reform efforts in Costa Rica, Argentina, and Chile. We then examine the intersection of migration and health policy and migrant realities in these three countries.

Immigration Law and Policy Reform in Costa Rica, Argentina, and Chile

Costa Rica

Migration from Nicaragua to Costa Rica peaked in the 1990s following structural adjustment policies in the 1980s and 1990s (Sandoval 2008). Although immigrant growth has slowed down in the first decade of the 2000s (Voorend 2013), Nicaraguans currently make up 75 % of the Costa Rican immigrant population. Until 2006, migration inflows were regulated under a migration law that dated back to 1986, which determined migration entry categories, visa and safe conduct procedures, restrictions to the length of stay, and the conditions under which entry could be denied (López Ruiz 2012). This relatively straightforward legal framework was adapted in 1995 to allow for seasonal work permits in the agricultural sector (Borge 2004).

In the 1990s, the state increasingly considered (Nicaraguan) immigration as a potential problem for integration, security, and unemployment, and in 2001 proposed a reform to the existing legal framework (Morales 2008, p. 15). This new law, which was presented in 2005 and came into effect in late 2006, strengthened control mechanisms that were not well developed in the 1985 law (López Ruiz 2012), emphasizing the surveillance of undocumented immigrants and regulation mechanisms to police foreign criminal activity. However, due to its punitive nature and the fact that "human rights, [were] almost overlooked" (López Ruiz 2012, p. 85), the law met with backlash and criticism that it would provoke discriminatory and xenophobic attitudes towards immigrants in Costa Rica, particularly immigrants from Nicaragua (López Ruiz 2012; Jiménez Matarrita 2009). Following pressure from civil society, the academic sector, and international organizations (López Ruiz 2012), a new reform was proposed in 2007 to "promote an administrative model to organize migration laws according to a human rights perspective, that would make possible migrants' access to Costa Rica's welfare

institutions and other public services offered by the State" (MIDEPLAN 2007, p. 49, authors' translation). The Legislative Assembly approved the General Migration Law (*Ley General de Migración y Extranjería* No. 8764) in July 2009, which subsequently entered into force March 2010.

This law, departing from the previous legislation, clearly incorporated the concept of integration (Kron 2011; López Ruiz 2012; Voorend 2013). The law, for the first time, commits the state to the social inclusion of immigrants in Costa Rican society "based on principles of respect for human rights; cultural diversity; solidarity; and gender equity" (General Migration Law 8764, art. 3). The law makes multiple references to international human rights, and highlights, possibly as a result of an openness to participation by different stakeholders during the process of its drafting, the "well-being of migrants and the respect for their rights" (López Ruiz 2012, p. 86). Given Costa Rica's reluctance to participate in regional integration processes, like the Central American Integration System, and its hesitancy to sign international conventions[1], this more inclusive language seems to be a result of domestic advocacy which nonetheless draws on human rights discourse. In contrast with Argentina and Chile, as we detail below, in Costa Rica regional integration and the transnational argument of extension of rights appear to be less important than domestic policy making processes in migration reform.

On a more critical note, despite the law's commitment to migrants' rights, the definition of integration in "economic, scientific, social, labor, education, cultural, and sports processes" (General Migration Law 8764, art 7) is vague, and there is no defined regulatory framework to ensure implementation (Voorend 2014). At the same time, while this explicit focus on social integration deviates from other Latin American migration laws' exclusive focus on migration control, the law has been criticized for the centrality it accords security issues (Kron 2011) and the greater authority given to Migration Police. The high costs involved with the regularization process and the requirements that migrants have social insurance to obtain regular migratory status have also been heavily criticized, as we discuss in detail in the following section.

Argentina

Argentina's immigration policies have a long and rich history and have recently undergone reform in 2004. Before 2004, immigration was regulated by the Videla Law, dating back to the military dictatorship (1976–1983) and sanctioned in March of 1981 (Novick 2008, 2010). This law was especially restrictive and aimed at reversing the principles of indiscriminate openness that characterized the overthrown Peronist constitutional government (Novick 2008).

The law's logic followed a national security paradigm, establishing different entry categories for immigrants (permanent, temporary, and transitory), carrying with them different statuses and rights. With a complex legislative structure of 115 articles, and an equally impressive public bureaucracy and control apparatus, migration policy was

[1] Costa Rica has not signed the following: (1) the C97 ILO Convention concerning Migration for Employment, of 1949; (2) the C143 ILO Convention concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers, both of 1975; and (3) the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, of 1990 (Bolaños 2009).

aimed at identifying internal and external enemies, subversive elements, and "illegal" and clandestine aliens (Domenech 2011).[2] It stripped migrants of their rights, dictated that they could be expelled from the country at any time, and sanctioned any citizen that cooperated with "illegal aliens" (Domenech 2011; Novick 2008; Ceriani Cernadas 2011). The law also established a long, expensive and complicated process of regularization, making regular migratory status practically inaccessible (Varela 2005; Torres 2012). The consecutive democratic governments during the 1990s continued to blame "illegal" immigrants for various social and economic national problems (Domenech 2008), and restricted the entry and stay of immigrants from neighboring countries (Oteiza and Novick 2000).

In 2003, after over 2 years of revisions, the *Ley de Migraciones de Argentina*, Law 25.871, was approved and officially instated in 2004 (Novick 2008). Existing analyses are in agreement that this law is a considerable step forward in terms of recognition of immigrants' rights (Novick 2008, 2010, 2012; Domenech 2008; Begala 2012; Jelin 2006; Asa and Ceriani 2005; Ceriani Cernadas 2011; Cerrutti 2011; Courtis and Pacecca 2007; Courtis et al. 2010; Pacecca and Courtis 2008; Giustiniani 2004). It was not until May 2010, however, that Decree 616/2010 implemented the actual operationalization of the law and sanctioned the legal ruling (Novick 2012) by establishing a regulatory framework to govern the 2004 Law and articulating the corresponding responsibilities for different state agencies.

Interestingly, in contrast with Costa Rica, Argentina has taken a proactive stance towards regional integration, and in 2002 signed an agreement with MERCOSUR members (including Bolivia which only became a full member years later) that guaranteed basic human rights for migrants from member (and some associate member) states, and aims to facilitate processes of regularization for migrants (Novick 2010). The current law is in many ways an extension of this agreement (Asa and Ceriani 2005), as it unequivocally recognizes the right to migrate (art. 4), right to education (art. 7), and health care (art. 8). The *Patria Grande* is an ambitious program that came into force in 2006 and aims at regularizing MERCOSUR member state immigrants' migratory status in Argentina, working to ensure immigrants' social rights.

While there is widespread agreement that the law is significantly more progressive than its predecessor in recognizing immigrants' rights, there is much less agreement on the effectiveness of the law's implementation and the extent to which migrants' realities have changed for the better. Some question the continuities and gray areas the law represents in terms of its emphasis on national security versus immigrants' rights, respectively (Begala 2012; Centro de Estudios Legales y Sociales CELS 2013; Ceriani Cernadas 2011; Courtis and Pacecca 2007; Domenech 2007, 2011). Scholars have also noted that the human rights approach the law embraces may simply represent a more subtle form of migration control with a "human face" (Domenech 2011, p. 67; Garcia 2010). The human rights principles then serve to legitimize the law's maintenance of measures against irregular immigrants, which were previously framed as part of the national security agenda (with the Videla Law). As such, although the law promotes immigrants' rights and

[2] Though we prefer the term irregular and use it in the paper, in this case we use the term "illegal" because it draws from direct quotes. It is important to accurately report this label as it represents the stigmatization of irregular migrants in Argentina in these documents.

integration, in essence Argentinean migration policy is reduced to promoting the regularization of immigration status, which is cumbersome and bureaucratic (Courtis and Pacecca 2007). Similarly, there are questions about the state's capacity to enforce the law as some public institutions create barriers to access to social services, which are contrary to the law's dictates (Begala 2012; Torres 2012). These formal and informal barriers created by state institutions have important effects on immigrants' social integration and, in particular, in immigrants' access to Argentina's health care system as we detail in the following section.

Chile

As in Argentina and Costa Rica, there have been recent efforts in Chile to reform migration law in order to make it more inclusive. However, while a new law was drafted by the president and sent to Congress in May of 2013, it is still pending. Therefore, Chile's current immigration policy still relies on the Migration Law (*Ley de Extranjería* N°1.094) which dates back to 1975. This law is the oldest in South America, established under the rule of Augusto Pinochet, and as part of broader immigration control efforts (Carrasco 2008). Immigration was seen as threatening and potentially dangerous (in the form of Communist-Marxist terrorists) and therefore the law was formulated during a time when the primary concern was national security (Stefoni 2011). It requires foreigners to procure one of three different visa categories: residency, permanent (available after signing three successive contracts with a Chilean employer), and tourist (for up to 3 months) (Carrasco 2008). Within the resident category, there are several subcategories: contract (requiring sponsorship by a Chilean employer, given for a year), student, temporary (given to those considered to benefit Chilean development), official (for diplomats and others in official capacities), and refugee/asylee (Carrasco 2008; Stefoni 2008).

Immigrants can enter Chile as tourists and then apply for residency at the Department of Migration and Foreigners (*Departamento de Extranjería y Migración*, DEM) at the Ministry of the Interior. However, in order to obtain residency, migrants have to present a work contract to receive a temporary visa (or they can present evidence of ties with Chilean nationals, pregnancy, or the necessity of medical treatment). This visa is valid for a year, renewable for a second, after which migrants can apply for residency. However, the visa is employer-specific and applying for residency is contingent on working for the same employer for the previous 2 years (Stefoni 2011). Employers must also commit to paying the return fare to the migrants' home country upon completion or termination of their employment contract. This puts migrants at a disadvantage when applying for work, as employers do not want to make this financial commitment.

Supreme Decree No. 597 was passed in 1984, and while it provides further regulations, it did not change the substance of the 1975 law (Demoscopica 2008). More recently, immigration policy in Chile has undergone several rounds of reforms. President Bachelet's government, between 2006 and 2010, has implemented a program to provide year-long visas for existing migrants (approximately 50,000 between 2007 and 2008), with the possibility of extension contingent on employment (Doña-Reveco and Levinson 2012). Immigrants are now seen as a social, rather than security, threat, with stereotypes of the poor, criminal, and underdeveloped/backward immigrant

(Stefoni 2011). For many years then, immigration policy was to tweak the legislation of 1975, without making any major changes. Stefoni (2011) calls this "a policy of no policy": that is, minor changes and some programs aimed specifically at migrants without defining a coherent framework for migrant rights in Chile.

However, Chile is currently in process of defining a new framework for national migration (Douchez-Lortet 2013). This reformulation is becoming especially important as Chile is an increasingly attractive destination country for people in neighboring countries (INE 2012; Stefoni 2011). Indeed, Chile has witnessed the highest growth in migrant stock growth in South America between 1990 and 2013 (Douchez-Lortet 2013) and the number of migrants residing in Chile increased from 1.2 to 2 % between 2002 and 2009 alone (Doña-Reveco and Levinson 2012). While the current law is still restrictive, Chile's commitment to regional integration initiatives creates pressure to reformulate its current policies. Like Argentina, in 2002 Chile signed the MERCOSUR Agreement that not only foments free movement of people but also guarantees human rights and equal treatment of MERCOSUR immigrants as compared to nationals (Ceriani Cernadas 2011; Novick 2010).[3] Chile approved this framework as a law in 2005 but it is still not fully implemented, going back and forth between the Senate and the Ministry of Foreign Relations.

In May of 2013, the Chilean government sent a draft of the proposed law to the chamber of deputies (the lower house of the bicameral Chilean congressional system) (Rodríguez and Labrin 2013), where it has so far been delayed in a series of bureaucratic revisions of different commissions. It currently awaits approval from the Committee of Interior Government, Nationality, Citizenship and Regionalization, after which it will be sent to the Human and Indigenous Rights Committee. Motions to speed up this process by allowing for parallel revisions were rejected by the chamber of deputies in September 2014. Despite these delays, this proposal indicates that Chile is increasingly positioning itself as a country open to immigration, and indeed immigration has increased substantially in recent years (Douchez-Lortet 2013).

In the following section, we focus on the relationship between migration policy and access to health care in these three countries, both in law and policy (that is, "on the books"), and in reality. We highlight how the structure of the health system and migrants social rights to health may be actively utilized as de facto migration policy.

The Intersection of Immigration and Health: Policy and Reality

Costa Rica

Access to Costa Rica's health care system requires *seguro social*, insurance issued by the CCSS—the social security agency which covers approximately 85 % of the Costa Rican population. Until 2009, immigrants were able to procure insurance relatively easily as it was not conditioned on migratory status. That is, regular and irregular

[3] While Chile is an Associate Member of MERCOSUR (since 1996), unlike Argentina which is a Full Member, it did sign the above 2002 agreement which guarantees equal treatments of migrants and citizens alike.

residents and aliens alike had access to health care services, provided they were either insured by their employers or paid the voluntary insurance fee. If immigrants (or nationals) did not have the *seguro social*, they would only be attended in during emergencies, and officially would be billed afterwards—although in practice a bill was rarely presented (Voorend 2013). In reality, the state financed the services provided in these cases. Other, more general non-emergency health care services, for the uninsured could be purchased at market price. Thus, eligibility criteria on their own did not strongly condition immigrants' access to health care, as much as the costs involved in purchasing insurance or treatment.

This changed radically with migration policy reform in 2009, as this new policy established affiliation with the CCSS as a new prerequisite for obtaining a regular migratory status. Indeed, to start the regularization process, an immigrant must be able to show their affiliation to the CCSS for the period s/he has been in the country (Law 8764, Article 7, paragraph 7). This is problematic for a couple of reasons.

First, making the *seguro* a requisite for regular migratory status gives the CCSS a direct regulatory role in Costa Rica's migration policy (Voorend 2013). More worrisome in terms of immigrants' access to health care, however, is the fact that the CCSS requires immigrants to have regular migratory status in order to gain access to social insurance. Following a request from the Migration Bureau (*Dirección General de Migración y Extranjeria*, DGME), in April 2012, the CCSS (2012, p. 1) established that "foreigners who apply for insurance for purposes of renewing their residence permit, must present their valid residence permit," (authors' translation) or have to demonstrate that the required paperwork is accepted and in process, in which case the CCSS can issue a temporary insurance for up to 2 months (CCSS 2012). This reform has two important implications. The first is that the DGME transferred part of migration control responsibilities to the CCSS. This represents an important shift of migration control inwards to other state institutions, creating additional layers by which the state controls migration. Second, this configuration of migration and social policy creates a "catch 22" situation: regular migratory status is a requisite for insurance, and vice versa. Despite temporary grace periods in which residence permit applications were accepted conditioned on the ensuing insurance from the CCSS, this situation hinders the regularization process and access to health care services alike (Voorend 2014).

The second concern with this reform is that it operates in a context where a significant proportion of nationals are not covered—the CCSS covers only six in ten economically active nationals (Sandoval 2012). However, the law demands that all immigrants be directly insured, a condition not met by nationals. Recent census data indicates that Nicaraguan immigrants were covered by direct insurance as salaried workers more often than Costa Rican nationals, 27 % compared with 22.3 %. Costa Rican nationals, however, have much higher rates of indirect insurance (41.4 versus 22.8 %) through an insured family member (INEC 2011). In the 2009 law, the CCSS determined that only regularized immigrants can be covered by family insurance, meaning that one regularization process per family is not sufficient to cover all family members. This creates serious barriers for immigrant families, who would have to pay the costs and endure the bureaucratic procedures as many times as they have family members to insure. Therefore, there is no option allowing dependent migrants to obtain indirect insurance coverage via a family member, which is how the largest share of Costa Ricans (41 %) are insured (INEC 2011).

Another important barrier to insurance is its cost. Immigrants working in the informal sector can only affiliate with the CCSS by purchasing insurance, which costs between US$ 35 and 60 a month depending on the sector of employment. The law also establishes a series of payments involved with a prolonged regularized stay in Costa Rica, estimated to amount to between US$ 373 and 800 (IIS et al. 2012). Additionally, the law establishes significant economic fines if documents are not renewed in time (Fouratt 2014). If these costs are compared with a domestic worker's minimum salary of US$ 287 (Instituto de Investigaciones Sociales IIS et al. 2012), and given that many do not even earn this amount (Martínez Franzoni et al. 2009), purchasing insurance may be cost prohibitive. Thus, the cost of regularization places a significant financial burden on migrants, who are often employed in low wage occupations.

Argentina

Unlike Costa Rica, Argentina's laws have been moving in a more inclusive rather than exclusionary direction. The Videla Law, dating back to 1981, denied undocumented migrants access to education and health services (Begala 2012; Ceriani Cernadas 2011; Domenech 2011; Giustiniani 2004; Pacecca and Courtis 2008). The 2004 Law, however, establishes that "the State […] will ensure equal access for immigrants and their families to the same conditions of protection and rights enjoyed by nationals, particularly with regard to social services, public property, health, education, justice, labor, employment, and social security" (Art. 6, Law 25.871, authors' translation). Following an important precedent set by the province of Buenos Aires in 2001 when it approved a law that guarantees every person access to public services regardless of migratory status (Novick 2008; Torres 2012), the 2004 Law states that immigrants not be "denied or restricted access, in any case, to the right to health […] irrespective of the migratory situation" (Art. 8, Law 25.871, authors' translation). The law also designates sanitary establishments as responsible for guaranteeing this undeniable right. Although it is uncommon in Latin America to explicitly and legally deny immigrants these rights, the law's unambiguous recognition of immigrants' social rights leaves little room for legal contestation (Ceriani Cernadas 2011).

In practice, however, immigrants' access to health services is not as universal (Torres 2012; Begala 2012; Cerrutti 2011; Courtis et al. 2010). Limits to access to health care services manifest in three interdependent ways. First, the law is interpreted in different ways by different institutions (Begala 2012). While some programs, such as the Ministry of Health's National Congenital Heart Program, now incorporate migrant population, there are others that still explicitly or implicitly exclude irregular immigrants. More subtle forms of exclusion include sanitary institutions demanding to see the National Identity Document (DNI) as a requisite for access—as is the case with a health care program for pregnant women called *Plan Nacer* (Courtis et al. 2010) thereby excluding irregular immigrants from their services (Begala 2012).

Second, there are cases in which the medical and administrative staff of sanitary institutions misinterprets, misapplies, or simply ignores the law (Torres 2012; Cerrutti 2011; Courtis et al. 2010). Provinces manage most health establishments, and this decentralization results in significant variation in access to and quality of treatment across provinces, though differences exist within

provinces as well. Medical and administrative practices, then, may form a barrier to immigrants' access to health care. Almost 10 years after adoption of the law, there are recurrent reports of denial of services by doctors and insistence by both medical and administrative staff that people present official Argentine documentation prior to receiving treatment (Torres 2012).

Finally, there are cultural barriers to access to Argentina's health care system (Torres 2012; Jelin 2006). The misunderstanding of behavioral codes and cultural traditions leads to serious communication problems between doctors and immigrant patients, especially among Bolivian and Peruvian immigrants. This "cultural fundamentalism" (Caggiano 2008) limits doctors' willingness to treat immigrant patients and reduces immigrants' inclination to seek medical attention (Torres 2012; Cerrutti 2011).

Overall, Argentina's 2004 Migration Law sets a high standard in terms of recognition of immigrants' social rights. However, migration policy in Argentina focuses almost exclusively on regularization programs (Domenech 2011), lacks a clear policy plan for enforcement, and entails limited state commitment to guaranteeing immigrant integration (Domenech 2011; Torres 2012; Courtis et al. 2010). Taken together, in practice this leaves ample room for institutions and social practices to limit immigrants' actual access to health care services with little recourse for migrants.

Chile

Currently, irregular immigrants in Chile do not have access to the public health care system. However, there are some specific programs aimed at undocumented pregnant women and children born to these migrants in Chile. Indeed, mothers of Chilean-born children can obtain a temporary visa from the government as anyone born on Chilean soil is by law entitled to citizenship (Cano et al. 2009). In a joint venture between the Chilean Ministries of Health and the Interior in 2007, all children younger than 18 years of age, regardless of the migratory status of their parents or guardians, are granted temporary residency and the right to health care (Stefoni 2011). In June 2008, the Ministry of Health passed ordinance No. 3229 which formally guarantees health care for children under 18 and pregnant women in Chile's public hospitals following the establishment of their temporary migrant status.

Since Peruvian immigrants constitute nearly one third of immigrants in Chile (Instituto Nacional de Estadística y Censos de Costa Rica INEC. 2011), there have also been bilateral agreements between Peru and Chile catering to Peruvian migrants. In 2002, the Peruvian General Consulate in Chile established, in cooperation with the Chilean Red Cross, a free medical clinic for Peruvian immigrants, regardless of migratory status. In 2009, the Chilean and Peruvian governments signed an agreement which entitles Peruvian pensioners in Chile to similar health and retirement benefits as nationals (Cabieses et al. 2012a).

Officially recognized international migrants, regardless of nationality, have access to primary care, either via the public (FONASA) or private (ISAPRES) system (Cabieses et al. 2012a). Legally, all migrants in Chile are entitled to emergency care (Demoscopica 2008; Doña-Reveco and Levinson 2012). However, in practice, access is not always granted. Furthermore, a recent study

found that not even half of Chile's immigrants were covered by health insurance, although the quality of health care is positively assessed when compared to care in their country of origin (OECD 2009). While Chile increasingly moves towards the norms established by international conventions, where "immigrants can receive prenatal care, child health care, emergency care, and the universal child vaccination program irrespective of their legal status in the country" (Cabieses et al. 2012a, p. 4), in practice there are barriers and immigrants do not know their rights and may lack care even in these basic areas (Cabieses et al. 2012a).

Conclusion

Our analysis reveals several similarities and differences in the relationship between immigration and health care policies and realities in Costa Rica, Argentina, and Chile. We summarize these differences in Table 2. *First*, all three countries have incorporated international human rights frameworks into their recent, current, or pending migration legislation, thereby recognizing—at least on paper—basic social rights for immigrants. However, this recognition appears to have different sources. We find that regional integration constitutes an important driving force for this tendency in Argentina and Chile, where MERCOSUR agreements have won important ground in recognizing member states migrants' rights, though Chile has yet to formalize this beyond extending the access of Peruvian migrants, the result of bilateral work. Subsequently, legislation in Argentina has further expanded migrants' rights beyond those from MERCOSUR countries, and pending legislation in Chile purports to do the same. In

Table 2 Migrants' access to health care in Costa Rica, Argentina, and Chile

		Costa Rica	Argentina	Chile
Migration reform adherent to international human rights discourse		Yes, 2009	Yes, 2004	No reform in migration law, some targeted programs for immigrants since 2006
Regional integration as a motor for migration reform		No	Yes	Yes
Creation of formal/legal barriers to health care access		Yes	No	Yes
Immigrant (adult) access to non-emergency health care	Regular	Yes	Yes	Yes
	Irregular	No	Yes	No
Degree of health care coverage for regular migrants		Extensive, relative equality	Broad, but stratified	Broad, but highly stratified
Irregular immigrants' (adult) access to emergency public health care (paid or free)		Yes (paid)	Yes (free)	Yes (free)
Irregular pregnant women and children's access to non-emergency health care		Yes (free)	Yes (free)	Yes (free)

Source: authors' own elaboration

contrast, in Costa Rica, the recognition of human rights originated domestically and occurred despite the country's reluctance to take part in regional integration efforts. The references to international human rights in the country's latest migration law may have their roots in international paradigms but were strongly mediated by domestic actors and policy processes.

We find variation in the extent of the recognition of human rights paradigms, with the continued centrality of regular migratory status as a requisite for health care access especially in Chile and, to a lesser extent, in Costa Rica. In Argentina, access to health care is legally unequivocal and undeniable, independent of migratory status. In Costa Rica, emergency health care services may never be denied (but may be charged for) but non-emergency access is mediated through affiliation to the country's social security, which is not easy for most immigrants to obtain. Chile has been moving to expand migrants' access to health services, but these efforts can only be partially effective without reforming the migration framework, an effort that is still pending.

Second, there are important differences in the legal and institutional barriers to access across the three cases. Notably, where Argentina's 2004 migration law removes all barriers to health care access and establishes the irrevocable right to public health care services, Costa Rica's 2009 migration law restricts migrants' access to health care services by creating a "catch-22" situation, conditioning regular migratory status on social insurance, and vice versa. Here, health care is used as a migration management strategy. Therefore, in laws and policies regulating access to social, among them health, services states are able to channel, regulate, and otherwise influence immigration policies and immigrant flows. Health and other social policies, especially in generous welfare states, can then be used as a tool to limit migrant rights and immigration more generally.

The most generous welfare regime, Costa Rica, which has the most extensive health care coverage, seems to be moving towards limiting immigrants' access to health services. Argentina, in contrast, is moving toward a more universal recognition of immigrants' social rights, in part owing to pressure by civil society, in accordance with regional and international treaties. Chile, a country with a strong market-based insurance system, is still awaiting more encompassing reform that recognizes immigrants' social rights. Here, health care access is not so much conditioned on citizenship or denizenship, but on purchasing power. In this way, the more generous welfare regimes might be less generous to (irregular) migrants, consistent with a response to the so-called welfare magnet argument. However, they do so not by limiting immigration outright but by making social security institutions important gatekeeping actors in the migration process.

However, once legal migratory status is achieved, the level of access to health care services is, just as for nationals, dependent on the extent of coverage and quality of the country's social policies and services. In Costa Rica, obtaining access might be more difficult than in Argentina, but once access is ensured health care coverage is broader and of higher quality. The strong public system makes for an extensive array of universal services, in contrast with the highly stratified systems in Argentina and Chile, where migrants' socioeconomic status, occupation, and the province determine the type and quality of health care. Given that in all three countries immigrants from neighboring countries typically find low-skilled and low-paying jobs in the informal sector, access to (quality) health care is more stratified in Chile and Argentine, but more

dependent on socioeconomic stratification than migratory status. Put simply, once regular status is established, a migrant has better access to high quality health care in Costa Rica than in Argentina or Chile.

Finally, across all three cases, there seems to be a mismatch between official laws and policies and de facto access to health care. That is, these macro level decisions are implemented, lived, and negotiated at the micro, everyday level: social policy is enacted at the counters of clinics and hospitals. There appear to be issues in the training of medical and administrative staff at health centers who sometimes turn away immigrants despite their right to receive service. This echoes inequalities along class, race, ethnicity, gender, and other lines that affect nationals as well. However, migrants are more vulnerable than nationals in some ways and may be less informed and willing to seek legal redress to these issues. Institutional requisites of regular migratory status, as created in Costa Rica in 2009, or in place for decades, as in Chile, form fertile ground for discriminatory practices. This is related, partially, to the perceived lack of legitimacy of extending such social rights to immigrants, especially irregular immigrants. This is consistent with theories of welfare magnets and questions about the social legitimacy of migrants' access to social services, where immigrants are perceived as disproportionately drawing on social services despite evidence to the contract (for example, Nicaraguans are more often directly insured by the CCSS than Costa Rican nationals). That said, the Argentinean case, where since 2004 this requisite was removed, shows the importance of the enforcement of state policy: in practice, regular migratory status is sometimes still demanded by doctors and administrative staff. The health care system, then, mirrors broader inequalities and discriminatory practices in society, and this extends to differentiating between immigrants and the national population.

We argue that historic migration legislation, the structure of the health care system, the social policy dimension of welfare regimes, and differences in implementation of global and regional norms and agreements account for this variation. In Chile, current migration legislation was born of a concern with national security during the dictatorship of Augusto Pinochet. Although recent governments have sought to amend this legislation in the interest of procuring contingent labor, the framework law from 1975 is still in place. Again, most immigrants (with the exception of pregnant women and children) can only access health insurance once their migratory status is made official and resolved. In Costa Rica, access to health insurance is tied to migratory status, and vice-versa creating a kind of catch-22 for immigrants trying to access health insurance and regularize their migratory status. Although in practice there are many hurdles to overcome to guarantee equal access, in Argentina immigrants have the same access to public health care as nationals, at least formally.

Our research suggests that existing social policy regimes, health care systems, and immigration policies interact to produce distinctive patterns of immigrants' social rights, consistent with existing research on Europe (cf. Sainsbury 2006). This indicates that immigration, a global phenomenon, may be exerting similar pressures across regions and countries, but interacting with local institutional arrangements and legacies—both of health and social policy and immigration policy—to produce different outcomes. Unlike developed countries, Latin American countries' welfare regimes are still under construction and undergoing large and often relatively rapid changes. Given their high levels of inequality, changes in welfare policies and the increase of South-South and

intra-regional migration can serve to increase or ameliorate existing inequalities. In addition, existing research on neoliberal globalization suggests that social rights are increasing in name, although not necessarily in practice.

Indeed, our analysis demonstrates that despite significant country differences, immigrants' actual access to health care in all three countries is not straightforward even when their rights are legally recognized. Even regular migrants' demand for health care services is sometimes considered illegitimate and denied. Migration is increasing across all three countries, and how they cope with the challenges of securing and providing social rights to immigrants has important implications for future inequalities. Centrally, the content and implementations of reforms inform our understanding of the relationship between the social policy dimension of existing welfare regimes and the extension of citizenship rights to migrant populations, rendering them social rights.

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