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Immigrants' Barriers to Accessing Social Policy in Argentina and Chile

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Abstract
Much attention has been paid to how immigrants are incorporated into welfare states in the Global North, but the Global South has been overlooked. This article studies barriers that immigrants face when accessing social policy in middle-income South American countries with high rates of immigration. With a focus on Chile and Argentina, I argue that immigrants' barriers to accessing social policy depend on political elites' views—as policies are expanded, policymakers will lower access barriers for universal policies, while they will raise more hurdles for targeted policies. This is because public officials view universal policies as "social rights" that include immigrants, while they view targeted policies as "costs" that must be contained. Barriers to access are measured through qualitative coding of social assistance, social pensions, and public health care that build on legal documents, information requests, and secondary literature from 1990 to 2022. Public officials' views are measured through 80 in-depth interviews. In analyzing barriers to accessing social policy, this study contributes to the literatures on comparative welfare states and immigration, as well as comparative social policy in middle income countries.

Keywords
social policy, immigration, South America

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Introduction

In the 2000s, Latin American countries massively expanded their welfare states and received an unprecedented number of immigrants. Social spending increased from 8.4 percent of the GDP in 2000 to 13 percent in 2021, and coverage of social assistance increased from 4 percent of the population in 2000 to 20 percent in 2016 (Cepalstat 2023). This meant that millions of citizens accessed basic income and better-quality services, many for the first time. As these policies became more inclusive for citizens, some became more exclusive for immigrants.[1] This matters, as immigration doubled in Latin America from 8 million immigrants in 2010 to 16 million in 2022 (Selee et al. 2023). In this context, a high-ranking immigration officer from Argentina expressed: "the state restricts [immigrants' access to social assistance because] resources are scarce."[2] Conversely, referring to health care, another bureaucrat from the same agency articulated that all immigrants receive free comprehensive medical care in all public hospitals in Argentina.[3]

Why did immigrants' hurdles for accessing social policy increase for some policies but not others as all social policies were expanded for citizens? This paper answers this question by bringing the discussion of welfare states and immigration to the Global South, and to Latin America specifically. The literature on the Global North has systematically analyzed the ways in which immigrants face more difficulty in accessing the welfare state (e.g., Römer 2017; Schmitt and Teney 2019; Lafleur and Vintila 2020; Koning 2021).[4] In the Global South, the incorporation of immigrants into the study of comparative social policy has been neglected in academic studies.[5]

Scholars studying social policy in the Global South have analyzed inequality along the lines of class, gender, and territory (e.g., Gough et al. 2004; Huber and Stephens 2012; Pribble 2013; Garay 2016; Martínez-Franzoni and Sánchez-Ancochea 2016; Tillin and Duckett 2017), but an additional layer of stratification has been overlooked: immigration status. This matters because immigrants tend to have less access to basic transfers and services than citizens, and

[1] An immigrant is defined as anyone who lives in a country different from their country of citizenship (i.e., noncitizen immigrants). Naturalized citizens are treated as native-born citizens in this study, as social policies do not tend to differentiate between them.

[2] Interview #55, Director of Dirección General de Inmigración, August 7, 2022, Buenos Aires. Own translation of interviews from Spanish to English. To protect the anonymity of participants, I only include their most relevant (for this study) job title, without detailing the specific years when they held that position.

[3] Interview #14, Press Secretary, Dirección Nacional de Migraciones, July 22, 2019, Buenos Aires.

[4] For a summary of the main research streams in the literature on migration, ethnic minorities, and the welfare state in Europe and the U.S., see Scarpa, Castles, and Schierup (2021).

[5] For an early and noticeable exception, see Hujo and Piper (2010b).

undocumented immigrants are in a particularly precarious situation. Pioneering works have started to incorporate immigration into the study of social policy in Latin America, but they have mostly characterized the phenomenon without explaining the causes of variation across policy sectors (Noy and Voorend 2016; Cruz-Martínez 2020; Voorend 2019; Vera Espinoza et al. 2021; Summers, Crist and Streitwieser 2022). This article contributes to the comparative social policy literature in Latin America by bringing this topic to the agenda and to the literature on the Global North by analyzing causes of variation across types of policies.

Systematic qualitative coding across social policy sectors from 1990 to 2022 measures the barriers that immigrants face for accessing the welfare state,[6] and 80 interviews to political elites in Argentina and Chile measure their views across social policies.[7] I argue that different policies will produce different trends in immigrant barriers. As all social policies are expanded in the 2000s, changes in the hurdles for immigrants will depend on the types of policies: public officials will increase barriers for targeted policies and decrease them for universal ones. This is an argument about how public officials' views and preferences shape their behavior: the more universal the policy is, the more policymakers see them as "social rights" that should include everyone (independently of their monetary cost), while they see targeted policies as a "cost" that must be contained (especially as coverage for citizens expands). Political elites' preferences and ideas have proven crucial for shaping migration policies (Brumat and Vera Espinoza 2023), and I argue that they also matter for shaping immigrants' access to social policy.

I selected Chile and Argentina because they are the two South American countries with the largest share of the population who is foreign-born in 2020, 5 percent in Argentina and 8.6 percent in Chile, and which have recently received among the highest number of Venezuelan immigrants (Del Real 2024). In addition, Chile and Argentina experienced different immigration trajectories, with Argentina being a country that has historically attracted immigration while Chile exhibits a sharp increase only since 2015. Finally, these countries are among the broadest welfare states in the region, thus exhibiting both universal and targeted noncontributory social policies, but with differences across their social assistance and health systems. These commonalities and differences, as well as the within-country variation across time and policy areas, allow me to rule out (national level) alternative

[6]Following a coding rubric, we analyzed laws, decrees, ministerial resolutions, information requests, and secondary literature. The product is detailed profiles per policy area in each country. Complete profiles are available in the Supplemental Appendix.

[7]I study the opinion of public figures who have a say in agenda-setting, policy design, and/or policy implementation, including policymakers, appointed high-level bureaucrats, policy advisers, and NGO leaders. I use these terms interchangeably throughout the article. Interviews were conducted in Argentina and Chile in 2019 and 2022.

explanations such as partisanship ideology, immigration regime, the political salience of immigration, the size of immigration, and public opinion.[8] Taken together, this article argues for the need of a new theory of immigrant incorporation into the welfare state in the Global South.

Immigration and the Welfare State: Literature Review

The welfare state can be a system of stratification by income (Esping-Andersen 1990). More broadly, the unequal way in which it incorporates workers, women, and immigrants produces stratification along the lines of class, gender, immigration status, race, and ethnicity (Williams 1995). Given the high levels of inequality and labor informality in the Global South, stratification is even more pronounced than in the Global North (Huber and Stephens 2001, 2012; Gough et al. 2004). Yet studies on social policies in the Global South have mostly omitted immigration status, race, and ethnicity (Hujo and Piper 2010a, 22). Analyses of stratification have included, instead, class, gender, and territory (e.g., Gough et al. 2004; Haggard and Kaufman 2008; Huber and Stephens 2012; Martínez-Franzoni and Sánchez-Ancochea 2016; Niedzwiecki 2018; Tillin and Duckett 2017; Arza et al. 2022).

Recent works on Latin American social policy have started to incorporate the degree to which social policies include immigrants (Cena 2014; Noy and Voorend 2016; Sala 2017; Cruz-Martínez 2020; Voorend 2019; Summers, Crist and Streitwieser 2022). However, these important works have been mostly focused on describing the phenomenon in one policy area, rather than comparing and explaining the causes of variation across sectors and countries. This is a central contribution of this paper: to propose causes for variation in access barriers in Latin America.

When explaining variation across wealthy countries, the main factors have been the role of the left and the type of welfare regime. But their precise effect is contested. On one hand, scholars following the "post-national model" in rich democracies argue that more generous welfare regimes with left-wing dominance will be more inclusive of immigrants. Detailed case studies have shown the limitations of the immigration-left-welfare regime connection, as countries that belong to the same welfare regime (e.g., Sweden and Denmark) have starkly different incorporation regimes—that is, while Sweden was inclusive Denmark was restrictive (Sainsbury 2012). On the other hand, the welfare chauvinist model that represents a backlash toward immigration predicts lower access of immigrants to the welfare state in precisely more generous welfare states with left parties that protect their insider constituency.[9] In Latin America, the literature has characterized and explained the

[8] For a summary of alternative explanations, see: Römer (2017), Schmitt and Teney (2019), and Römer and Bjerre (2022).

[9] See Boräng (2015), Römer (2017, 175–78) and Schmitt and Teney (2019) for a summary of the chauvinist and post-national models in wealthy democracies.

impressive expansion that social policy exhibited in the early 2000s and also found contrasting results on the role of partisanship ideology (Huber and Stephens 2012; Pribble 2013; Garay 2016; Altman and Castiglioni 2020).

Beyond welfare regime and partisanship ideology, other explanations include: voting rights, global human rights framing, signing of international agreements, immigration policies, and immigration flows (Sainsbury 2012; Noy and Voorend 2016; Acosta 2018; Schmitt and Teney 2019; Voorend 2019; Römer and Bjerre 2022). In this paper, I rule out these country-level explanations by focusing on intra-country variation across policies. The same government (left or right) in the same context of immigration regimes and trends, increases barriers for immigrants' access to some social policy sectors while it decreases them in others.

Explaining Immigrants' Barriers to Accessing Social Policy

Building from the literature on wealthy welfare states, this paper measures and analyzes immigrants' barriers to accessing social policy (Soysal 1994; Faist 1996; Sainsbury 2012; Helbling et al. 2017; Lafleur and Vintila 2020; Solano and Huddleston 2020; Römer et al. 2021; Koning 2022). While very useful, these conceptualizations and measurements have limitations when applied beyond European welfare regimes (Esping-Andersen 1990), to contexts of high levels of informality and more targeted than universal social policies due to lack of stable funding (Gough et al. 2004; Huber and Stephens 2012; Pribble 2013; Martínez-Franzoni and Sánchez-Ancochea 2016).[10] The dependent variable, barriers to access, is the degree to which immigrants with different legal statuses face hurdles when accessing the main noncontributory transfers and services of a country.

These barriers can appear at the design stage of a policy (Legal Barriers) or at the moment of its implementation (Administrative Barriers). Legal barriers are detailed in constitutions, laws, and decrees. For example, the law can explicitly require non-citizens for more residency years than citizens. There can also be barriers when a policy is implemented, as when the institution (e.g., the ministry or agency) in charge of implementation adds a requirement that was not originally present in the law (e.g., the need to have a bank account). These administrative decisions do not need approval by the legislature and tend to change more rapidly than laws (Del

[10] There are a number of indexes that measure immigrants' inclusion to social policies, including the Migrant Integration Policy Index (MIPEX, Solano and Huddleston 2020), the Immigrant Exclusion from Social Programs Index (IESPI, Koning 2022), Immigration Policies in Comparison Project (IMPIC, Helbling et al. 2017), and its associated Migrant Social Protection Database (MigSP, Römer et al. 2021). I learn and build from these invaluable indexes, adding an in-depth analysis of legislation, government documents, and secondary literature on a yearly basis, and differentiate legal and administrative barriers across four immigration statuses.

Real 2024, 7).[11] My assumption is that barriers to access social policy translate into less effective access to basic transfers and services.

What explains differences in the barriers that immigrants face to access social policy? Opening the black box of differences across policy sectors, I argue that the inclusion of immigrants depends on the type of policy: universal policies will be more inclusive of immigrants while targeted ones will tend to be more exclusive. This is because political elites in Latin America view universal policies as "social rights" that must include immigrants and not just citizens, while they see targeted policies as "costs" that must be contained. This is an argument about what politicians and bureaucrats think when designing and implementing social policy expansion. Political elites' views and philosophies have proven crucial for shaping migration policies (Brumat and Vera Espinoza 2023) and their implementation (Cohen 2014). Their views on immigrants' access to universal versus targeted sectors will shape the types of barriers they impose. Their positions change laws and regulations and directly shape the possibility of immigrants' access to the welfare state. Figure 1 presents a summary of the argument.

Due to fiscal limits, most policies in Latin America are targeted, and not universal, and they have been expanded for citizens (Garay 2016; Arza et al. 2022) and restricted for immigrants. The increasing exclusion of immigrants from social pensions, in particular, responds to the fact that this is a targeted policy by definition (only elderly people without enough contributions are eligible in Latin America), so political elites (both from the left and the right) want to restrict their access to immigrants as a way to cut costs. Targeted or selective benefits are defined as those only provided *to a segment of the citizen population*, generally (but not only) to those in economic need (Titmuss 1976). Targeted social policy tends to generate a zero-sum logic: the idea that one person's access denies another one of such benefits.

In contrast, universal policies in Latin America are more inclusive than targeted ones for immigrants. Universal policies are those "services available and accessible to the whole population…social rights of all *citizens*" [emphasis added] (Titmuss 1976, 38). In its classic Marshallian definition (1950, 28) social rights are rights of *citizenship* to economic and social welfare and mainly include social services. The state must guarantee access to these social rights that protect citizens from life risks.[12] In Latin America,

[11] I do not study the important barriers that happen at the moment of service delivery, and that is a central limitation of this article. I made this decision because the literature on social policy and immigration in Latin America is scarce, at least from a comparative politics perspective, and therefore the laws on paper and their administrative implementation are a necessary first step for analysis. Another limitation of this paper is that barriers do not distinguish by immigrants' country of origin, race, or ethnicity, they only distinguish between their immigration status.

[12] This definition of universalism as social rights of citizenship is different from the Human Rights Approach that holds universality in access to basic social protection on the basis of being a human and following the commitments acquired through signing International Human Rights' Treaties (Abramovich and Pautassi 2006; Asa and Ceriani Cernadas 2010).

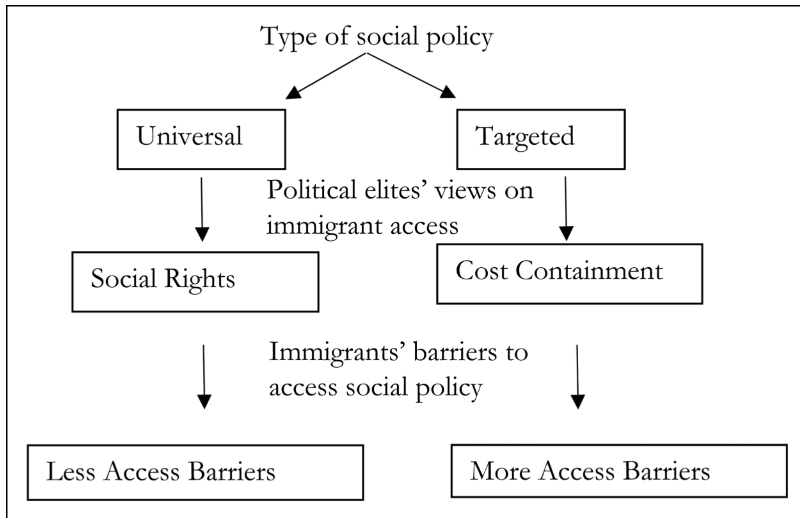

Figure 1. The Main Argument.

public officials view these policies not just as citizenship rights, but as social rights that should also include immigrants, and so concerns about budgetary constraints are brushed aside to protect such rights.

This argument is unexpected for at least two reasons. First, the literature on migration studies has identified discrepancies between politicians' discourses and legislation/policies on paper, or "discursive gaps."[13] As a result, we should not necessarily expect that what political elites *say* and what they actually *do* coincide. Second, the argument about universal policies being more inclusive than targeted ones is unexpected because in Europe welfare chauvinism—or the political opinion that welfare should be given just to citizens, excluding immigrants—has been present in some universal systems, especially among radical right parties, but also among the left (Andersen and Bjørklund 1990; Ennser-Jedenastik 2018). Most political elites in Latin America (at least at the national level) do not seem to exhibit welfare chauvinism in the case of universal policies while they do believe that targeted policies should prioritize citizens. Similar to what has been found for rich democracies, universal regimes tend to be more inclusive of immigrants (Banting 2000; Morissens and Sainsbury 2005; Römer 2017; Schmitt and Teney 2019). Contrary to this literature, there can be important variation within countries that exhibit both universal and targeted policies. Taken together, this theory on political elites' views applies to middle-income countries in the Global South that generally

[13] For a summary of this literature, see Acosta and Freier (2015, 663).

combine both universal and targeted policies. These beliefs, I argue, are not dependent on partisanship ideology, or even on public opinion.

Alternative Explanations

Political ideology is an alternative explanation to political elites' views. In the European literature, left parties tend to be more inclusive of immigrants (Graauw and Vermeulen 2016), while radical right parties are more exclusive (Koopmans, Michalowski and Waibel 2012). This is only partly true in Latin America: left-wing politicians have been promoters of reducing immigrants' barriers to access universal policies, but they have been as likely as right-wing leaders to increase barriers to immigrants' access to means-tested policies. In the case of social pensions, for instance, politicians across the ideological spectrum have imposed the need to show decades of residency to access them. More generally, alternative explanations that only vary at the national level, cannot explain within country variation across social policies.

Citizens' public opinion could also potentially affect political elites' views and barriers for immigrants' access to social policy (Banting and Koning 2017, 112; Magni 2022). Immigrants are seen as less "deserving" of welfare than natives (van Oorschot 2006), and this may shape policymaking. Previous work has even emphasized the difference across universal and targeted policies in citizens' attitudes about whether immigrants deserve—or not—to access social policy (Niedzwiecki and Ponce de León 2025). However, it is not clear that public opinion has a direct effect on political elites' actions, and there is some evidence that politicians ignore public opinion when designing policies (Jacobs and Shapiro 2000), or at least policies that are relatively insulated from the public eye.

An additional alternative explanation is related to the possibility that policymakers view health (and also education) as different from the rest of the policies, independently of their universalism. Political elites may be more open to immigrants' access to health (and education) due to a rational calculation of wanting to avoid illnesses and strengthen the labor force, versus generating "dependency" from social assistance. This is plausible; however, the case studies show how, in Chile, it was very hard for immigrants to access health care until the view around its universality partly changed. This within-country across-time variation rules out the health/education versus social assistance hypothesis.

A final alternative explanation could be the actual overall cost of expanding universal versus targeted policies, the idea being that targeted policies are more expensive than universal ones and thus more barriers should be enacted for more expensive policies. However, this is not the answer, as policymakers are aware that incorporating immigrants into universal policies (such as public health care or education) is more expensive than providing social assistance (such as food stamps). Universal policies require larger bureaucracies and more expensive services.

Case Selection

South America has seen one of the sharpest increases in the rate of immigration in the last decade. This is partly because most of the 7.4 million Venezuelans who were forced to leave their country since 2015 settled in another South American country (Selee et al. 2023). Scholars analyze South America as a region that has adopted open discourses around immigration since the twenty-first century, going against the restrictiveness trend in Europe and the United States (Acosta and Freier 2015; Acosta 2018). Most South American countries are part of the Mercosur Residence Agreement, and share relatively similar (and rights-based) entry policies, especially for intraregional migration (Del Real 2021).[14] These immigration regimes have been labeled as "liberal" and "progressive" (Cantor, Freier and Gauci 2015; Acosta 2018; Camacho and Freier 2022a, 4).[15]

Within South America, I select Chile and Argentina from 1990 to 2022. The time frame corresponds to the most recent (and uninterrupted) democratic period with primarily intraregional migration trends. Chile and Argentina have the largest share of the population who is foreign born in 2020, 5 percent of the population in Argentina and 8.6 percent in Chile (Figure 2). However, they share different immigration trajectories. Argentina is a case of long-term and steady immigration rates, with a prevalence of intraregional immigration since the 1990s. Conversely, Chile is a newer immigrant recipient with a sharp increase since 2015. Figure 2 shows that the migrant share of the population was less than 1 percent in the 1990s and more than doubled between 2015 (3.6%) and 2020 (8.6%). The recent increase is mainly related to the crisis in Venezuela, and also Haiti (Rojas Pedemonte, Silva and Gálvez 2019, 262–63).

Any person born in Chilean or Argentine territory automatically acquires that nationality (ius solis) and their children born abroad can also receive their parents' nationality (jus sanguini). Both countries started the 1990s with dictatorship-era migration laws that were punitive and had a clear national security bias. Argentina moved to a human rights' paradigm with the 2003/4 Immigration Law, while Chile only reformed its dictatorship-era legislation in 2021 (Ceriani Cernadas 2011, 76; Camacho and Freier 2022b). Since the 2000s, it has been relatively "easy" to acquire temporary residency for Mercosur members who fall under the "Residence Agreement," and can therefore live and work in another member state

[14] However, only three South American countries (Argentina, Uruguay, and Brazil) have included Venezuelans in the benefits of the Residence Agreement (Del Real 2024, 4–8).

[15] Acosta and Freier (2015) also note that the liberal discourses have been at times accompanied by the exclusion of immigrants from Africa, Asia, and the Caribbean, who are extra-Mercosur immigrants. In addition, the Chapters in Guizardi's (2021) new edited volume emphasize an increase in hate speech toward immigration in South America, including in Chile (Guizardi and Mardones 2021) and Argentina (Canelo, Gavazzo, and Nejamkis 2021).

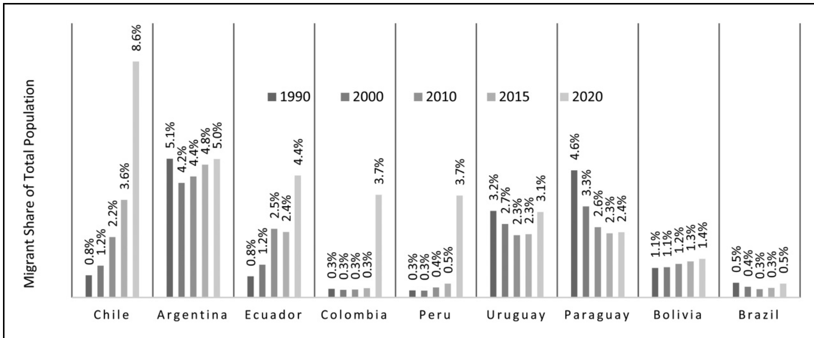

Figure 2. Migrant Share of the Total Population in South America, 1990–2020.
Note: People born outside of their country of current residence. Mid-year data for South American countries, except Venezuela due to data unreliability.
Source: Migration Policy Institute Data Hub based on the UN Department of Economic and Social Affairs, Population Division.

for two years (renewable and with the possibility of becoming a permanent resident), as long as they have a clean criminal record.[16] The situation of Venezuelans is different: while Argentina has extended the benefits of the residence agreement to Venezuelans, Chile has not. This means that Venezuelan migrants in Chile are required to prove economic sufficiency and a consular visa to acquire legal residency status (Del Real 2024, 4, 11). The consequence is a high prevalence of immigrants (and Venezuelans in particular) with an undocumented status in Chile.[17] Applying for documented residency for citizens of countries who are not part of Mercosur is more onerous. In both countries, having permanent or temporary residency gives immigrants access to a national ID. Figure 2 shows the percentage of immigrants with permanent or temporary status, but it does not include those with an undocumented status.

Both countries implemented extraordinary regularization processes that reflect (in an underestimated way) the number of immigrants with an undocumented status in a

[16] The Residence Agreement was signed in 2002 and is fully implemented in Argentina since 2009 for citizens of Uruguay, Brazil, Paraguay, Bolivia, Chile, Peru, Ecuador, Colombia, Guyana, Suriname, and more recently, Venezuela. In Chile the agreement is implemented for citizens of Argentina, Bolivia, Uruguay, Paraguay, and Brazil but not for nationals of associate members (Doña Reveco 2022; Del Real 2021, 3).

[17] Since the implementation of the Migration Law in Chile in 2021, the number of illegal or irregular entries to the country increased from 16,000 in 2020 to 56,856 in 2021, 53,875 in 2022, and 35,000 as of September 2023 (Forbes Staff, September 26, 2023). Before 2021, the consular visa requirement also increased irregularity among newcomers (Tijoux and Ambiado 2019).

given year. In Argentina, before 2004, under the 1981 dictatorship-era "Videla Law," a majority of immigrants did not have access to legal residency. Democratic governments implemented "amnesties" and regularized around 500,000 immigrants in total in 1984 and 1992 (Mármora 2004). The 2004 Migration Law expanded immigrants' access to a national ID, especially for members of Mercosur countries. Between 2004 and 2010, 1.5 million immigrants received a legal temporary or permanent residency (Calvelo, Couto and Osorio 2015). In Chile, an estimated 30 percent of the migrant population in 1997 had an irregular status, and the government enacted extraordinary regularization processes in 1998 (50,000 people were regularized), 2007 (50,000), 2018 (155,000), and 2021 (Thayer 2019, 312, 316, 320). In both countries, limited capacity of the main immigration agency, technical issues with the migration office's online platform, self-sufficiency requirements, and the Covid-19 pandemic contribute to the (current and historic) lack of (or "tenuous") documentation among immigrants (Del Real 2024).[18]

In terms of social policy, Argentina and Chile are among the most generous welfare states in the South, with a combination of both universal and targeted policies (Huber and Stephens 2012). Within these countries, I choose noncontributory public health, social assistance, and social pensions. These sectors cover the main social risks of the population, including poverty and illness. Selecting noncontributory policies matters because the high levels of labor informality in Latin America (and in Chile and Argentina in particular) means that most people would not have access to basic services and transfers if they were contributory based.

Qualitative Data Collection

This paper is based on the qualitative coding of three noncontributory sectors (public health, social assistance, and social pensions) from 1990 to 2022 and 80 in-depth interviews of political elites in Argentina and Chile. I conducted in-person (66) and Zoom (14) interviews in 2019 and 2022 in Buenos Aires (58) and Santiago de

[18] Interview #42, Senior Economist of Global Protection in World Bank, June 16, 2022, Buenos Aires; Interview #45, Director of Clínica Jurídica sobre Migración y Asilo del CELS, CAREF y UBA, June 23, 2022, Buenos Aires; Interview #54, Director of Dirección de Radicaciones from Dirección Nacional de Migraciones; July 8, 2022; Interview #64, Chair of Departamento de Extranjería y Migración, July 21, 2022, Santiago de Chile; Interview #69, Director of Departamento de Extranjería y Migraciones, July 7, 2022, Santiago de Chile; Interview #73, Executive Director Vicaría de Pastoral Social Caritas, July 27, 2022, Santiago de Chile; Interview #74, Chief of Departamento de Estudios, Dirección de Gestión de Datos, Servicio Nacional de Migraciones, July 27, 2022, Santiago de Chile; Interview #77, Migration Adviser from Gabinete Ministerial, Subsecretaría Servicios Sociales del Ministerio de Desarrollo Social y Familia, July 28, 2022, Santiago de Chile; Interview #78, Director of Clínica Jurídica de la Universidad Diego Portales, July 28, 2022, Santiago de Chile.

Chile (22). They lasted between 40 to 90 minutes. Interviews included high-ranking appointed public officials and leaders of civil society organizations. Participants directly design or implement social or immigration policies or are experts in these areas due to their advising, advocacy, and/or lobbying activities. For selecting interview participants, I first mapped and approached strategically placed people in relevant governmental and nongovernmental institutions (usually aiming for the highest-ranked person) and then asked the participant for references to other potential interviewees. This combination guarded against snowballing's danger of getting stuck in a self-referential narrative loop.

The qualitative coding exercise started in 2019 and ended in 2023.[19] The goal of this exercise was to measure the hurdles that immigrants face to access the main social policies in comparison with citizens. In other words, the index measures immigrant-specific barriers (e.g., years of residency in the country), as opposed to barriers that affect everyone (e.g., low funding or poor administrative capacity). Table 1 presents the four types of barriers included in the measure. These are barriers that emerge both from social policy eligibility criteria (i.e., legal and administrative hurdles depending on legal status and labor market status), as well as from immigration policies (i.e., how relatively difficult it is to acquire legal residency) . The coding differentiates between immigrants with a documented and an undocumented status.[20]

For each country-sector, together with a group of research assistants, we coded the main noncontributory social sectors: public health, social assistance, and social pensions, and the implementation of Mercosur's Residence Agreement from 1990 to 2022.[21] The qualitative coding exercise was based on a coding scheme and thorough reading of social policy and immigration legislation, administrative documents, official websites, secondary literature, and information requests.[22] The coding

[19] See the profiles and codebook in the Supplemental Appendix.

[20] The coding includes five resident categories: citizens (both native-born and naturalized, the base category), permanent and temporary residents (with country-specific definitions of who belongs in these categories), residents with an irregular status (people with some documentation but with no documentation from the country of residence), and residents with an undocumented status (people who are not able to prove their identity in any way).

[21] The Mercosur Residence Agreement allows immigrants who are nationals of another Mercosur country ("nacionalidad Mercosur") and who have a clean criminal record for the last five years to access legal residency. This means that regional immigrants (80% of all immigrants in South America, CAREF and CELS 2023, 3) can receive legal residency solely based on nationality, without showing proof of economic self-reliance or employment, and independently of their current immigration status or the way they entered the country. This Agreement has been credited with providing legal residency to 3,500,000 immigrants in the signatory countries by 2022 (CAREF and CELS 2023, 3).

[22] I developed the first draft of the coding scheme in collaboration with Prof. Koen Voorend at Universidad de Costa Rica. I am grateful for the superb work on Argentina and Chile of lead-research assistants Francisca Godoy and Sofía Vidotto.

Table 1. The Four Types of Barriers That Immigrants Face for Accessing Social Policy.

Immigrants' Barriers for Accessing Social Policy (IBASP)			
1. Legal-Explicit	The law establishes different access criteria for citizens and immigrants	0–3	
2. Legal-Implicit	The law does not explicitly establish different access criteria for citizens and immigrants, but legal requirements for everyone make it harder for immigrants to access	0–3	0 No Barrier 1 Low Barrier 2 High Barrier 3 Exclusion
3. Administrative	The state agency in charge of providing the service or transfer adds obstacles not present in the law	0–3	
4. Legal Residency*	Level of incorporation of Residence Agreement to national legislation.	0–2	0 Residency Agreement is incorporated into national legislation and applies to nationals of both Member and Associate states. 1 Residency Agreement is incorporated into national legislation but applies only to nationals of Member states. 2 Residency Agreement is not incorporated into national legislation

[a]Immigrants' Barriers for Accessing Legal Residency are only coded for residents with an irregular or an undocumented status.

is conservative: when in doubt due to lack of information or in-between scores, the research team erred on the side of lower rather than higher barriers. Table 2 lists the policies included in each sector across time and the Supplemental Appendix includes a list of all the primary and secondary sources that we consulted to construct the coding.

Immigrants' Barriers in Argentina and Chile

The systematic coding of the main noncontributory social policies in Argentina and Chile reveals that there is no sector that is fully inclusive of all immigrants, even when on paper they may appear as such. Immigrants have a harder time accessing the welfare state than citizens simply because of their status as noncitizens. Yet, there are differences across types of policies. Figure 3 shows the barriers that foreign-born residents face when trying to access the main noncontributory

Table 2. List of Social Policies Included in the Qualitative Coding Across Time and Sector.

Country	Sector	Social Policies
Argentina	Social Assistance (targeted)	1996–2001: Plan Trabajar 2002–2008: Plan Jefes y Jefas de Hogar Desocupados 2009–2022: Asignación Universal por Hijo/Embarazo para la Protección Social
	Social Pensions (targeted)	1990–2015: Pensión no Contributiva por Invalidez; Pensión no Contributiva para Madre 7 Hijos; Pensión no Contributiva por Vejez 2016–2022: Pensión no Contributiva por Invalidez, Pensión no Contributiva para Madre 7 Hijos, Pensión Universal para el Adulto Mayor
	Health (universal)	1990–2022: Subsistema de Salud Pública
Chile	Social Assistance (targeted)	1990–2001: Subsidio Familiar 2002–2011: Chile Solidario, Subsidio Familiar 2012–2022: Seguridades y Oportunidades, Subsidio Familiar
	Social Pensions (targeted)	1990–2007: Programa de Pensiones Asistenciales 2008–2021: Pensión Básica Solidaria 2022–2023: Pensión Garantizada Universal
	Health (targeted and universal)	1990–2022: Fondo Nacional de Salud (FONASA), prestaciones no contributivas.

social policies. The higher the score on the y-axis, the higher the barrier. The minimum score is "0" (citizens and immigrants do not encounter different obstacles) and the maximum is 11 (complete exclusion in each of the four types of barriers), as Table 1 describes.

Figure 3 shows that barriers for immigrants increase for targeted social pensions and social assistance over time while they decrease for public health care in both Argentina and Chile. While in the 1990s public health care was more restrictive than social assistance and social pensions in both Argentina and Chile, this relationship is reversed in the context of social policy expansion in the 2000s.[23] What explains these trends? In Argentina, the general view among public officials is that public health and education (both universal policies in this country) do not (and should not) exclude immigrants; in contrast, social assistance does exclude some

[23] In the Supplemental Appendix (p. 142), I show that these changes in restrictions did not apply to all immigrants equally, as their documentation status made a difference. There is a gap in access to social policies between documented and undocumented residents, with differences across policies. As we move from documented to undocumented residents, social pensions exhibit increases in barriers while the gap decreases across time in health care. I do not focus on this dimension in this paper, but analyze it in the larger book project.

immigrants, and those limits are justified partly due to scarce resources.[24] Conversely, in Chile, where both noncontributory health care and social assistance are means-tested (i.e., targeted), policymakers have imposed barriers for immigrants in both sectors, with barriers decreasing in health care only since 2016. I argue that changes in politicians' views (from health care as a "cost" to health care as a "right") explain this variation.

Targeted Policies

Social Assistance and Social Pensions in Argentina and Chile

Social pensions and social assistance include monetary transfers to families, people with disabilities, and the elderly in poverty. They are targeted benefits by definition in Latin America: only those who pass the income-test (i.e., who prove that they are "poor") can access them. Throughout the 1990s, these noncontributory transfers were narrowly targeted to the extremely poor in Argentina and Chile, and this became a problem in the late 1990s—the narrowly targeted safety net was insufficient for supporting the increased number of people who were unemployed or worked in the informal sector and therefore did not have access to contributory benefits. As the demand for noncontributory transfers increased, governments expanded these policies for citizens by increasing spending and coverage levels, in the context of a commodity boom and the election of left-leaning candidates, Néstor and Cristina Kirchner in Argentina and Ricardo Lagos and Michelle Bachelet in Chile (Arza et al. 2022). As these policies were including more citizens, they increased the barriers for immigrants.

Argentina. Before 1997, there was no explicit requirement in the Law or in administrative documents that imposed higher hurdles for immigrants compared

[24] Interview #7, Secretary of Articulación de Política Social from Ministerio de Salud y Desarrollo Social, July 16, 2019, Buenos Aires; Interview #11, Social Assistant of Secretaria Ejecutiva de la CONARE, July 19, 2019, Buenos Aires; Interview #14, Press Secretary, Dirección Nacional de Migraciones, July 22, 2019, Buenos Aires; Interview #18, Representative from CONARE from Ministerio de Desarrollo Social, July 23, 2022, Buenos Aires; Interview #20, Subdirector Ejecutivo de Administración, Anses, July 24, 2019, Buenos Aires; Interview #21, General Secretary of Anses, July 24, 2019, Buenos Aires; Interview #27, Subcoordinadora Operativa de Migrantes, Defensoría del Pueblo, Ciudad Autónoma de Buenos Aires, July 29, 2019 and July 4, 2022, Buenos Aires; Interview #29, Coordinator of Programa SUMAR, Ministerio de Salud, July 30, 2019, Buenos Aires; Interview #34 National Director of Abordaje Integral de Programas Nacionales, August 1, 2019, Buenos Aires; Interview #35, Adviser to Dirección Nacional de Abordaje Integral de Programas Nacionales, August 1, 2019, Buenos Aires; Interview #42, Senior Economist of Global Protection in World Bank, June 16, 2022, Buenos Aires.

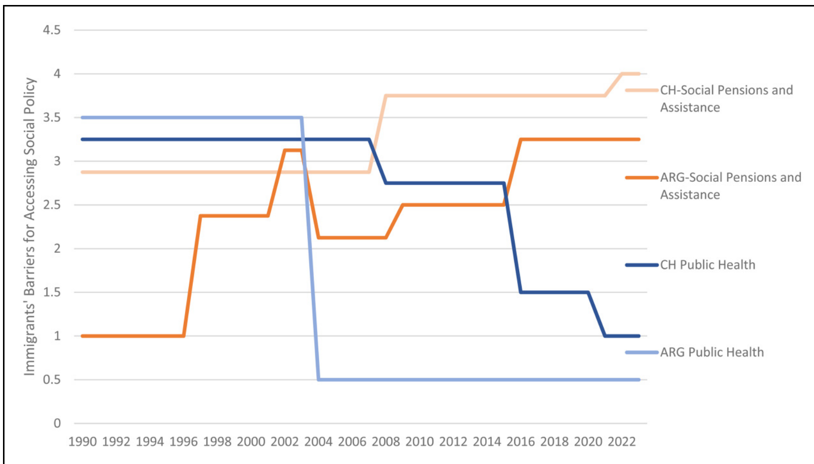

Figure 3. Immigrants' Barriers to Access Noncontributory Social Policy in Argentina and Chile.
Note: Social assistance and social pension scores are averaged for ease of interpretation. Scores across immigration statuses (documented and undocumented) are averaged because for a single individual the barriers across immigration statuses are not cumulative. For example: a permanent resident does not add to their own barriers those of temporary residents. Legal and administrative barriers are added up because types of barriers do accumulate for a single person within a single immigration status. The minimum score is "0" (citizens and immigrants do not encounter different obstacles) and the maximum is 11 (complete exclusion in each of the four types of barriers). See Table 1 for a list of the four types of barriers, Table 2 for a list of policies included, and the Supplemental Appendix for country-policy profiles.

with Argentine citizens when accessing social pensions or social assistance. Since 1997, social pensions for the elderly have required having an Argentine ID (given only to citizens and documented residents) and 20 to 40 years of residency in the country. The decades-long residency requirement, in particular, makes it impossible for newcomers to access. Barriers increased even more from 2016 to 2019, when the agency in charge of implementing these policies (Anses) changed the way in which years of residency were counted—from entry to the country to the acquisition of legal residency. For those residents for whom these two dates did not coincide, they could be denied access to this pension, as the government used the lowest number.[25] By 2019, only 2.4 percent of the recipients were foreign-born

[25] Interview #21, General Secretary of Anses, July 24, 2019, Buenos Aires; Interview #27, Subcoordinadora Operativa de Migrantes, Defensoría del Pueblo, Ciudad Autónoma de Buenos Aires, July 29, 2019 and July 4, 2022, Buenos Aires.

(Lieutier 2018, 85). In addition, during the 2020 Covid pandemic many recipients saw their noncontributory pension canceled if they had left Argentina before the pandemic and tried to reenter when all borders were closed, and therefore all entry-points were considered "illegal."[26]

The trends for social assistance are similar: barriers increased in 2002 with the incorporation of a national ID requirement and in 2009 with the enactment of Asignación Universal por Hijo that carried a two to three years of residency requirement (Ceriani Cernadas, Cyment and Morales 2011; Cena 2014; CAREF 2021). In 2015, more than 8,000 foreign-born residents were excluded from this CCT due to not reaching the minimum three years of residency required (UNICEF et al. 2017, 24). Given all of these barriers, only 1.3 percent of recipients are foreign-born, compared with a total of 4.9 percent foreign-born residents in 2019 (Lieutier 2018, 85; United Nations, Department of Economic and Social Affairs, Population Division 2019). This increase in legal and administrative barriers for social pensions and social assistance affects all immigrants, but particularly those with an undocumented status.

Personal interviews with policy experts and high-level bureaucrats revealed consensus around the idea that the state has limited resources, and therefore not all immigrants can access these expanded (for citizens) policies.[27] In particular, the opinion among these political elites is that only immigrants who "deserve" these policies because they "contribute to society" should be able to access targeted noncontributory social assistance and social pensions.[28] The necessary "contribution to society" is defined differently by interviewees but the general idea is that being present in Argentina and having a national ID seems "reasonable," in many cases because it means that people have paid taxes and, therefore,

[26] Interview #27, Subcoordinadora Operativa de Migrantes, Defensoría del Pueblo, Ciudad Autónoma de Buenos Aires, July 29, 2019, and July 4, 2022, Buenos Aires.

[27] Interview #4, Director of Servicio Jesuita al Migrante, July 12, 2019, Buenos Aires; Interview #20, Subdirector Ejecutivo de Administración, Anses, July 24, 2019, Buenos Aires; Interview #21, General Secretary of Anses, July 24, 2019, Buenos Aires; Interview #27, Subcoordinadora Operativa de Migrantes, Defensoría del Pueblo, Ciudad Autónoma de Buenos Aires, July 29, 2019 and July 4, 2022, Buenos Aires; Interview #34 National Director of Abordaje Integral de Programas Nacionales, August 1, 2019, Buenos Aires; Interview #42, Senior Economist of Global Protection in World Bank, June 16, 2022, Buenos Aires; Interview #43, Director of Social Protection CIPPEC, June 22, 2022, Buenos Aires.

[28] Interview #32, Coordinator of Programa de Fortalecimiento de Migrantes, Ministerio de Justicia y Derechos Humanos, August 1, 2019, Buenos Aires; Interview #49, High-level Bureaucrat in charge of Datos Estadísticos y Observatorio Social de la Administración Nacional de la Seguridad Social ANSES.

they are "contributing" to funding these policies.[29] A high-ranking official from the Social Security Agency (Anses) explained the resource-limitation mentality for noncontributory transfers:

> "Today Argentina has 30% of poverty…We need to be more efficient…everything is money…I am controlling more, yes. If you falsified information, I disqualify you, if you do not reach the three years [of residency in Argentina], I disqualify you…The law is defined first but then regulated in this agency…I can interpret the law."[30]

The focus of this politically appointed high-ranking officer is on cost containment, understanding that there are limited resources in Argentina (given the high levels of poverty), so tighter enforcement of immigrants' eligibility criteria is one way to contain those costs.[31] The previous quote also reflects the relevance of administrative barriers for increasing eligibility controls. The Law did not change, but in its enforcement the implementing agency made it harder for immigrants to access social assistance. Implementing agencies such as Anses have great room of maneuver when it comes to interpreting how the law is enforced, in this case by making sure that immigrants with less than three years of residency do not receive the CCT, which had not previously been enforced to the same extent.

The number of years of residency that are required to access social assistance and social pensions is a topic of discussion for public officials. Noncontributory elderly pensions, for example, require 20–40 years of residency depending on the specific policy. A high-ranking officer from Argentina's National Migration Agency remembered a closed-door meeting in which they discussed the residency requirements for noncontributory pensions with representatives from the Ministry of Social Development:

> "The director comes with her team and tells me that they are going to reduce [the residency requirement] to 10 years and asks me what I think about that. I think it's total nonsense…How do they establish that criteria?…[In a sarcastic tone:] Ultimately, it's the idea that [immigrants] have to be here, that you have to be thankful I let you

[29] Interview #20, Subdirector Ejecutivo de Administración, Anses, July 24, 2019, Buenos Aires; Interview #21, General Secretary of Anses, July 24, 2019, Buenos Aires; Interview #34 National Director of Abordaje Integral de Programas Nacionales, August 1, 2019, Buenos Aires; Interview #42, Senior Economist of Global Protection in World Bank, June 16, 2022, Buenos Aires; Interview #43, Director of Social Protection CIPPEC, June 22, 2022, Buenos Aires; Interview #49, High-level Bureaucrat in charge of Datos Estadísticos y Observatorio Social de la Administración Nacional de la Seguridad Social ANSES.

[30] Interview #21, General Secretary of Anses, July 24, 2019, Buenos Aires.

[31] It should be noted that targeted policies are relatively inexpensive for the state, and therefore restricting access to immigrants likely does not save a significant amount of funds.

> come to my house. You have to demonstrate roots…in 10 years you have the "Argentine card" that gives you rights…[In a serious tone:] Now, is it wrong that the state restricts access? We would like to give [social pensions] to everyone, obviously, but resources are scarce, budgets are scarce. You have to restrict."[32]

While many criticize the long-residency and ID requirements for excluding many immigrants,[33] most support some restrictions. The previous quote shows that, even for someone relatively critical of the residency requirement in principle ("We would like to give [social pensions] to everyone"), there needs to be some restriction because "resources are scarce." For many political elites, restricting immigrants' access to social pensions is mandatory for a state with scarce resources, and having "roots" in the country seems to be the main criteria for inclusion.

Chile. Barriers for immigrants also increased in the 2000s in Chile, after the expansion of social pensions and social assistance. These policies are targeted—potential recipients have always needed proof of income to access them. In 1990, elderly pensions required three years of residency, which increased to 20 years since 2008 while also incorporating a Chilean ID requirement that year. This partly explains the very low coverage of social pensions for immigrants. More than 13 percent of 65+ year olds are covered by noncontributory pensions,[34] yet only 0.7 percent of the recipients are foreign born.[35]

Chilean administrations also increased immigrants' barriers for accessing social assistance as this policy was expanded for citizens. A Chilean ID has been an administrative requirement since 1990—to sign up for social assistance, potential recipients need to enroll in a registry (called "Ficha CAS") that requires a national ID. A representative of the Servicio Jesuita Migrante explained that accessing social assistance requires having a RUT (Chilean ID Number), and most immigrant families that go to that NGO do not have it, so the NGO must directly provide food or subsidize documentation fees.[36] Hurdles increased with the implementation of the new Migration Law No. 21,325 in 2022 (Art. 16), as a minimum of two years of residency is now also required.

[32] Interview #55, Director of Dirección General de Inmigración, August 7, 2022, Buenos Aires.

[33] Interview #41, Executive Director of CAREF—Comisión Argentina para Refugiados y Migrantes, August 5, 2019, Buenos Aires; Interview #52, Coordinator of Red Nacional de Migrantes y Refugiados en Argentina, July 27, 2022, Buenos Aires; Interview #57, National Director of Centros de Atención a la Justicia (CAJ), July 15, 2022, Buenos Aires; Interview #49, High-level Bureaucrat in charge of Datos Estadísticos y Observatorio Social de la Administración Nacional de la Seguridad Social ANSES.

[34] Pension Advisory Council of Chile. 2018. Effective Coverage of PBS for the Elderly.

[35] Data provided through an information request (Transparencia) by Instituto de Previsión Social (Social Prevision Institute).

[36] Interview #66, Director of Área Social del Servcio Jesuita a Migrante, July 22, 2022, Santiago de Chile.

The increasing barriers to access social pensions and social assistance respond to Chilean political elites' view that these policies entail "costs" that must be contained. The incorporation of the 20-year residency requirement for noncontributory pensions since 2008 takes place in the context of social policy expansion and an increase in immigration rates; in other words, in the context of increased spending and costs. Their idea is that people who "deserve" these pensions have stayed in Chile and contributed to the country for decades.[37] If they have not contributed actively, they are seen as a burden to society in old age.

An analysis of the parliamentary debates around the new Migration Law revealed these perceptions of "burden to society". In 2022, Chile reformed its migration policy (Migration Law No. 21,325) and incorporated a minimum of two years of residency for immigrants accessing any noncontributory transfer that implied a "fiscal burden" (carga fiscal). More specifically, any noncontributory transfers funded by public resources must have a residency requirement of at least two years. The fact that the discussion of funding—and "fiscal burden"—is included in the migration law shows the view of the legislators around immigrants' access to noncontributory targeted policies.

The view that benefits that imply a "fiscal burden" should include an amount of residency years to access was present from the original legislative project presented by President Piñera in 2013 to its final approval in 2022. To be sure, there were dissident voices that called for the elimination of the residency requirement for immigrants on the basis of legal equality between migrants and citizens and against the idea that immigrants are an "economic burden." This included the social director of the *Servicio Jesuita Migrante*. However, this perspective was not majoritarian. The main view among legislators during these debates was that immigrants' accessing state-sponsored social assistance/pensions were an economic/fiscal/state "burden" (Biblioteca del Congreso Nacional de Chil*e*, 17, 140, 143, 175, 897, 945, 1426).

Health Care in Chile

The noncontributory (i.e., free for the patient) tier of the public health system in Chile is mostly targeted to the poor, but also includes a universal component. Since 2005, pregnant women and children can access health services in the public health system (called FONASA), independently of their income. The rest of the population must pass a means-test—the household income cannot be higher than the minimum salary, among other income requirements. This combination of universal and targeted characteristics produces mixed results in terms of political elites' views and barriers for access. While barriers decreased with time, they took much longer than in Argentina's heath sector. Before 2015, a national ID was required to

[37] Interview #63, International Labour Organization (ILO) Program Officer, July 21, 2022, Santiago de Chile.

access the public system, and without being enrolled in the system, access to services was limited.[38] Undocumented immigrants, in particular, were effectively excluded.[39]

This, and other barriers, produced differences in access to the health system between immigrants and citizens. Around 14–16 percent of immigrants (compared with 2.5–5% of citizens) were not affiliated to any health system between 2006 and 2017 (Cabieses, Oyarte and Delgado 2017; Benítez and Velasco 2019). Progressive incorporation of undocumented pregnant women and children from 2008 to 2015 contributed to lowering barriers for some immigrants. In 2016, the Chilean ID requirement was finally eliminated for everyone. While these changes have improved access to health care, gaps still exist, especially for newcomers. There was a large variation depending on the time of arrival: around 55 percent of immigrants were not enrolled in any health system within the first year of arrival compared with 20 percent from the second year onward in 2015. In 2017, after the elimination of the ID requirement, there was 40 percent unenrollment the first year and 10 percent from the second year onward (Benítez and Velasco 2019).

Major health care expansion in Chile came with AUGE-GES (Universal Access to Guaranteed Rights) in 2004, a program that guarantees quality and timely access to a list of the most common illnesses. However, lowering barriers for immigrants took one more decade. I argue that the delay has to do with a “cost containment” view among political elites that comes from the mostly targeted characteristics of the system. Pribble (2013) details how the AUGE reform was a policy priority for President Ricardo Lagos, who had campaigned with the promise that all Chileans would have access to health care without having to wait a long time (Pribble 2013, 48–49). Pribble explains how fiscal sustainability was one of the main concerns that motivated this reform: the fact that the public system covered most health risks but received a minority of contributions. A former Undersecretary of Health with President Lagos administration explained in a personal interview that the only time he remembers immigrants being mentioned in the AUGE discussions was when the team discussed “health tourism” and rapidly agreed that this should be avoided, and therefore the program had to be limited to documented residents.[40] The fiscal responsibility focus continued being central after the reform, and that may partly explain why it took longer to incorporate immigrants. A high-ranking officer in Chile’s Servicio Nacional de Migraciones remembers that the barriers to

[38] Interview #62, Chief of División Jurídica Ministerio de Salud, July 20, 2022, Santiago de Chile; Interview #63, International Labour Organization (ILO) Program Officer, July 21, 2022, Santiago de Chile; Interview #69, Director of Departamento de Extranjería y Migraciones, July 7, 2022, Santiago de Chile.

[39] Interview #78, Director of Clínica Jurídica de la Universidad Diego Portales, July 28, 2022, Santiago de Chile.

[40] Interview #65, Undersecretary of Health during Ricardo Lagos’ administration, July 21, 2022, Santiago de Chile.

accessing health care before 2016 were related to the question of costs and whether medical services would be reimbursed. In her own words:

> "What happened [before 2016] was at the discretion of the personnel in the health facility…they decided whether to provide medical services [to immigrants] or not. If they provided medical services, the question was how they would be reimbursed. If it was a serious medical issue, it was expensive, and that influenced the professional's decision of whether to provide services or not. Would [the medical facility] recover what they had invested in the person? When that person had no ID, that was spending without reimbursement…and that was the main barrier to provide health services."[41]

The calculation of the "cost" of the patient was in the minds of service providers at the time of deciding whether to provide immigrants' access to health care or not, because it was not clear whether they would be reimbursed for those services. The more serious the illness, the more expensive the treatment, and the lower the chances that immigrants with an undocumented status would receive medical treatment. Some service providers responded by creating a "fake" temporary number ("RUT ficticio o estándar") to access the health system, which allowed FONASA to reimburse the health center, and this was a crucial incentive for providers.[42] However, these responses were left at the discretion of the local health center.

This "cost containment" logic that is common in targeted policies is combined with a social right that includes immigrants' view of health care codified in the 2016 Resolution and in the 2022 Migration Law. In 2016, the Ministry of Health under President Michelle Bachelet defined in a resolution (circular) that undocumented immigrants should be considered as lacking economic means and should therefore automatically receive access to the noncontributory tier of the public system. This is because, according to the resolution, health care should be of universal access (Ministerio de Salud de Chile 2016).

In the 2022 Migration Law, the "right to health" (Art. 15) is provided to all foreigners, including those with an "irregular migratory status" in the same condition as nationals, following the precedent set in the 2016 resolution. It is noteworthy that the original legislative project presented by President Piñera in 2013 required that health services that are funded by fiscal resources (i.e., the noncontributory public health system) include only documented residents with a minimum of two years of residency, in the same terms as social assistance and social pensions discussed above. This initial legislative project only guaranteed access to health to

[41] Interview #68, Unidad de Estudios del Servicio Nacional de Migraciones, July 25, 2022, Santiago de Chile.

[42] Interview #65, Former Undersecretary of Health during Ricardo Lagos' administration, July 21, 2022, Santiago de Chile; Interview #68, Unidad de Estudios del Servicio Nacional de Migraciones, July 25, 2022, Santiago de Chile; Interview #73, Executive Director Vicaría de Pastoral Social Caritas, July 27, 2023, Santiago de Chile.

minors, pregnant women, and for emergency services (Biblioteca del Congreso Nacional de Chile, 17). In 2018, after incorporating feedback from the debate in the Chamber of Deputies, President Piñera presented a modified project that eliminated the two-year residency requirement and included all immigrants to health services (Biblioteca del Congreso Nacional de Chile, 51). This mixed legislative view that health is a right versus a "fiscal burden" has to do with its design both as a universal and a targeted policy.

Universal Policies: Health Care in Argentina

Public health care is a universal social right for citizens in Argentina enshrined in provincial constitutions and in international treaties. Every citizen, irrespective of income or type of job, is legally allowed to go to a public hospital or clinic at no cost for the patient to receive from primary to high complexity care, thus making this system universal for citizens since the 1940s, at least on paper.[43] Before 2004, many undocumented immigrants were excluded from health care. The Migration Law enacted during the military dictatorship (popularly known as the "Videla Law", after Argentina's infamous dictator) required immigrants to present proof of identity and of legal residency in Argentina to receive health care, and health practitioners were legally obliged to report undocumented immigrants (and to communicate their address) to the national migration authority (1981 Law No. 22,439, Art. 103; CELS 1998). While health care may not have been denied, the obligation to report undocumented immigrants, and the risk of being deported, acted as a deterrent for seeking health care and promoted a practice of refusing health services to undocumented immigrants (Caggiano 2006, 252–53).

This Law lasted for 20 years and was still valid after the transition to democracy in 1983 (Nejamkis 2016). Throughout the 1990s, the Immigration Law from the Dictatorship jeopardized the right to health care as undocumented immigrants were provided medical services and then reported to the authorities.[44] In other words, undocumented immigrants were not excluded from the system due to a "cost containment" logic, but because health care followed the national security bias of the migration law.

Since the enactment of the 2004 Migration Law, the health system significantly lowered its barriers for immigrants. The Law established that every person physically present in Argentina has the right to access public (and free for the patient) health care. The right to health must be protected for everyone, regardless of migration status, as undocumented residents cannot be excluded from free and public health services (Law No. 25,871, Art. 8). These changes certainly decrease barriers,

[43] In practice, due to quality deficiencies, only 30-40% of the population without health insurance use the public system (Cetrángolo and Goldschmit 2018, 12, 26).

[44] Interview #45, Director of Clínica Jurídica sobre Migración y Asilo del CELS, CAREF y UBA, June 23, 2022, Buenos Aires.

particularly for undocumented immigrants, but there are still obstacles for accessing health care. This is because public health care is decentralized in Argentina, so provinces have a high level of autonomy. In fact, by August 2024, at least four provinces that share borders with another country (Rio Negro, Mendoza, Salta, and Jujuy) passed legislation to charge access to public health to foreigners without legal residency in Argentina.[45]

The decrease in barriers since 2004 corresponds with a significant expansion of health care in Argentina (Huber and Stephens 2012; Niedzwiecki 2014). Since the early 2000s, the government expanded primary health care through the distribution of first-aid kits and the reimbursement to public clinics and hospitals for services provided to those without health insurance. Health spending increased from 8 percent of the GDP in 2000 to 10 percent in 2015 (CEPAL 2022) Why did immigrant barriers to accessing health care *decrease* in a context of expansion for citizens, while they *increased* in the case of social assistance and pensions (see previous sections)? This responds to the view by politicians and policymakers that, different from targeted benefits, universal public health care in Argentina is a right for everyone—and not just citizens.

Public officials, politicians, and experts alike are highly critical of the 1981 Dictatorship Law and agree that health care (and also education) is "different" from noncontributory targeted policies, because health care is a "right," which cannot be denied to anyone.[46] Even high-ranking officials from the right-wing administration of President Mauricio Macri, who supported a more punitive approach to immigration, acknowledge that there is a right to health that must be provided to every resident independently of their immigration status.[47]

The following three quotes are some of the examples from the interviews around the idea that health care is a right. Note that these short quotes are generally followed by a comment (not included here) on how targeted transfers are "different." An undersecretary in the Public Defender's Office at the City of Buenos Aires who

[45] See Supplemental Appendix for details. In addition, important barriers appear at the moment of service delivery (Jelin 2006; Cyment 2019), which are not included in this analysis.

[46] Interview #7, Secretary of Articulación de Política Social from Ministerio de Salud y Desarrollo Social, July 16, 2019, Buenos Aires; Interview #14, Press Secretary, Dirección Nacional de Migraciones, July 22, 2019, Buenos Aires; Interview #27, Subcoordinadora Operativa de Migrantes, Defensoría del Pueblo, Ciudad Autónoma de Buenos Aires, July 29, 2019 and July 4, 2022, Buenos Aires; Interview #30, Adviser in Subsecretaría de Coberturas Publicas Sanitarias, Ministerio de Salud July 30, 2019, Buenos Aires; Interview #34 National Director of Abordaje Integral de Programas Nacionales, August 1, 2019, Buenos Aires; Interview #43, Director of Social Protection CIPPEC, June 22, 2022, Buenos Aires.

[47] Interview #6, Director of Dirección Nacional de Migraciones, July 16, 2019, Buenos Aires. Interview #7, Secretary of Articulación de Política Social from Ministerio de Salud y Desarrollo Social, July 16, 2019, Buenos Aires.

represents immigrants explained: "Our [national] Constitution says so, it guarantees a minimum floor…the right to health…for primary health and emergency services."[48] Similarly, a high-ranking secretary from the Ministry of Social Development explains that "[t]he 1996 Constitution of the City of Buenos Aires is very open [to immigrants], the moment you set foot in the City you have access to the health system."[49] Finally, a high-level advisor from the national Ministry of Health described the process of including immigrants to a primary health care program partly designed by him: "When we started designing [the program], we had the question of what to do with people without a National ID…[but ultimately decided] not to make it exclusionary…[the goal is to] keep and maintain the universal access to health…that was the idea behind the program, never to restrain access."[50]

It is these perceptions that shape the almost full inclusion of immigrants to the universal health system in Argentina. Three issues are worth mentioning. On one hand, the change in views among policymakers was not automatic—it took many years after the enactment of the 2004 Migration Law for political elites to view immigrants' access to health care as a right. In one of the first analysis of health and immigration in Argentina soon after the implementation of the 2004 Law, Jelin (2006) compiled a book that describes barriers that immigrants still faced for accessing the system, and especially undocumented immigrants (Jelin, Grimson and Zamberlin 2006).

On the other hand, and relatedly, the role of organized civil society was crucial in the process of the 2004 Immigration Law that expanded access to health care to immigrants. The Law was possible thanks to pressure from civil society organizations, including human rights and church-based organizations, unions, academics, and immigrants (Ceriani Cernadas 2011, 76).[51] Scholars in Argentina have systematically analyzed the crucial role that organized civil society played in the design and implementation of the 2004 Law (Correa 2004; Brumat and Torres 2015; Nejamkis 2016).

Finally, not all politicians support immigrants' unrestricted access to health care, but these voices are far from being a majority, including among the right. Canelo, Gavazzo and Nejamkis (2021, 106–7) show how a right-wing Congressman introduced a bill in 2018 to restrict immigrants' access to health. However, there was no agreement among the right-wing coalition government at the time, and therefore

[48] Interview #27, Subcoordinadora Operativa de Migrantes, Defensoría del Pueblo, Ciudad Autónoma de Buenos Aires, July 29, 2019 and July 4, 2022, Buenos Aires.

[49] Interview #7, Secretary of Articulación de Política Social from Ministerio de Salud y Desarrollo Social, July 16, 2019, Buenos Aires.

[50] Interview #30, Adviser in Subsecretaría de Coberturas Publicas Sanitarias, Ministerio de Salud July 30, 2019, Buenos Aires.

[51] Interview #3, Director of Especialización en Migración y Asilo desde una perspectiva de los Derechos Humano de la Universidad de Lanús, July 11, 2019, Buenos Aires; Interview # 23, Coordinator of Área de Capacitación, CAREF — Comisión Argentina para Refugiados y Migrantes, July 24, 2019, Buenos Aires; Interview #40, Director of Dirección Nacional de Migraciones, August 5, 2019, Buenos Aires.

this bill never made it to the floor. In December 2024, shortly before this article went to press, the radical right government of President Javier Milei expressed interest in charging "foreigners" for the use of public hospitals (La Nación 2024). These efforts deserve further research.

Conclusion

Research on welfare states and immigration in wealthy democracies has not distinguished between targeted versus universal policies, and the literature on social policy in Latin America has overlooked exclusion due to being an immigrant. This paper centers the issue by showing that immigrants face particular barriers to access social policy compared with citizens, and that such barriers vary across universal and targeted policies. The systematic coding of sectors reveals the existence of barriers in both universal and targeted policies in Argentina and Chile, but it also confirms that there is a clear difference between more inclusive universal services and more exclusive targeted policies as these policies are expanded for citizens. I argue that this is because politicians view universal policies as a "social right" to be provided to immigrants and citizens alike (independently of their cost), while targeted policies are seen as a cost that must be contained.

This "social right" (for universal) versus "cost containment" (for targeted policies) logic is not obvious, as universal policies (such as health care in Argentina) are actually more expensive than targeted social assistance. In addition, European welfare chauvinist views show the simultaneous support for universal —and exclusive to citizens—social policies (e.g., Ennser-Jedenastik 2018), a trend that (at least until now) I do not observe in Chile and Argentina. Future research should focus on whether this decades-long agreement is being altered by radical right-wing parties in government.

While this research confirmed that social policies stratify along the lines of citizenship status, this does not mean that we should get rid of the welfare state. This is because, as Norma Ginsburg eloquently explained, the welfare state institutionalizes class, gender, and racial divisions and inequalities; but without the welfare state these inequalities would be even more substantial (Ginsburg 1992). Social policies in Argentina and Chile have a number of barriers that make them harder for immigrants to access basic income and services when facing life risks such as old age, poverty, sickness, and unemployment; but without these policies their situation would be even worse.

The Venezuelan refugee and migration crisis makes the inclusion of immigration to the analysis of social policy more relevant than ever in South America. Increases in immigration can produce an eruption of xenophobic discourses. More universal welfare policies can possibly decrease the power of these discourses. This paper suggests what specific barriers within policies need to be modified to combat exclusion in Argentina and Chile and potentially avoid an increase in xenophobic appeals.

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