A Welfare Magnet in the South?

Migration and Social Policy in Costa Rica

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A WELFARE MAGNET IN THE SOUTH?

Migration and Social Policy in Costa Rica

KOEN VOOREND

Erasmus University Rotterdam
Make it happen.

A Welfare Magnet in the South?
Migration and Social Policy in Costa Rica

Sociale Welvaart als Magneet
Migratie en Sociaal Beleid in Costa Rica

Thesis

to obtain the degree of Doctor
from the Erasmus University Rotterdam
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Voor Lara en Louk,
For their intense, beautiful,
chaotic love.

Y para Ariana,
For keeping it all together.

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Acronyms

BNA	Bi-National Agreement on Labour Migration Flows between Costa Rica and Nicaragua
CCSS	Costa Rican Social Security Fund (*Caja Costarricense del Seguro Social*)
DGME	General Directorate of Migration and Foreigners (*Dirección General de Migración y Extranjería*)
DR-CAFTA	Dominican Republic and Central America Free Trade Agreement
FODESAF	Fund for Social Development and Family Allowances
IMAS	Mixed Institute of Social Assistance
IOM	International Organization for Migration
NGO	Non-Governmental Organization
RHS	Right Hand Side
TTE	Temporary Work Card (*Tarjeta de Trabajo Estacional*)
UNHCR	United Nations High Commissioner for Refugees

Abstract

A Welfare Magnet in the South?
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The incorporation of Nicaraguan migrants in Costa Rica's welfare arrangements is polemic, especially because the country's 'exceptional' social policy regime and its flagship healthcare institution are under (financial) pressure, and the principle of universalism is in erosion. In this context, this research analyses the ways in which migration and social policy interact, and migrants' access to social services, specifically healthcare. It constitutes an important empirical contribution to a public policy debate in the country centred around the idea that Costa Rican health services constitute a welfare magnet for Nicaraguan migration, through which the legitimacy of their claim to health services is questioned. It is argued, however, that there is little empirical foundation for this idea.

At the same time, it speaks to larger debates on social exclusion and universalism. It discusses institutional processes of exclusion, in the form of restrictive state reactions to migrant inclusion in the context of the social security crisis. Despite acknowledgement of human rights frameworks, the state finds inventive ways to circumvent these and restricts migrants' access to healthcare by giving a central role to healthcare institutions in (internal) migration management. This research then argues that such state reactions correlate to negative perceptions of migration, migrant incidence and the legitimacy of migrant healthcare demands of officials of crucial institutions for migrant inclusion. However, such perceptions are not backed by empirical data.

Finally, the research strongly argues the need to go beyond the recognition of formal social rights and look at the extent and ways in which migrants actually access social services. Based on focus group discussion with migrants and primary survey data, this document contains an elaborate discussion of the factors that determine mi-grants' access to public health insurance, health services and medicine. The findings suggest that regularization is a necessary, but insufficient, condition for social integration, thereby questioning the state's limited understanding of integration, which focuses exclusively on the regularization of 'illegal' migrants. More importantly, however, it shows that universalism in social policy does not apply equally to nationals and migrants, and is in fact, stratified.

Samenvatting

Gezondheidszorg als Aantrekkingskracht.
Migratie en Sociaal Beleid in Costa Rica
KOEN VOOREND

De integratie van Nicaraguaanse migranten in Costa Rica's sociale zekerheid zorgt voor veel controverse, vooral omdat het 'uitzonderlijke' sociale stelsel en haar belangrijkste zorginstelling onder (financiële) druk staan, en het principe van universalisme is verzwakt. In deze context wordt in dit onderzoek gekeken naar de manier waarop sociaal beleid en migratie op elkaar inwerken, met de zorgsector als casus. Het vormt een belangrijke empirische bijdrage aan een debat over de integratie van migranten, rond het idee dat de Costa Ricaanse gezondheidszorg een magneet is voor Nicaraguaanse migratie. Terwijl hierdoor de legitimiteit van hun aanspraak op gezondheidszorg in twijfel wordt getrokken, wordt in dit onderzoek vastgesteld dat er weinig empirische basis is om dit idee te onderbouwen.

Daarnaast spreekt dit document tot algemene discussies over *social exclusion* en universalisme. De beperkende reacties van de overheid ten opzichte van migratie vormen institutionele processen van *exclusion* die suggereren dat overheden in hun retoriek trouw kunnen zijn aan internationale kaders voor mensenrechten, maar in de praktijk inventieve manieren weten te vinden om deze kaders te omzeilen. Dit onderzoek stelt vervolgens dat dergelijke reacties correleren met negatieve standpunten van ambtenaren van cruciale overheidsinstanties voor de integratie van migranten, over het relatieve gewicht van migranten in sociale programma's en hun illegitieme aanspraak op gezondheidszorg. Echter, deze standpunten worden niet ondersteund door empirische gegevens.

Tot slot wordt in dit onderzoek geconcludeerd dat het noodzakelijk is om verder te gaan dan enkel een analyse van formele sociale rechten en dat onderzocht moet worden in hoeverre migranten daadwerkelijk toegang hebben tot de Costa Ricaanse gezondheidszorg. Op basis van focusgroep gesprekken met migranten en primaire survey data, wordt een uitgebreide discussie gevoerd over de factoren die de toegang van migranten tot de publieke gezondheidszorg beïnvloeden. Regularisatie van migrantenstatus blijkt noodzakelijk maar geenszins toereikend voor succesvolle sociale integratie van migranten. Daarmee plaatst het onderzoek kritische kanttekeningen bij de beperkte visie van de staat die zich uitsluitend richt op het regulariseren van 'illegale' migranten en zich verder niet bekommert om hun sociale integratie. Belangrijker is echter dat het laat zien dat universalisme in sociaal beleid niet van gelijke toepassing is op staatsburgers en migranten.

Resumen

Un imán de bienestar en el Sur.
Migración, política social y universalismo en Costa Rica
Koen Voorend

La incorporación de migrantes nicaragüenses en los servicios sociales en Costa Rica ha sido y sigue siendo muy polémica, especialmente porque el régimen de política social 'excepcional' institución insignia de la salud están bajo presión (financiera), y el principio del universalismo se está debilitando.

En este contexto, esta investigación examina la interacción entre la política social y la migración, a través del caso de la salud pública. Supone una importante contribución empírica a un debate público en el país en torno a la idea de que los servicios de salud de Costa Rica constituyen un imán de bienestar para la migración nicaragüense, a través de la cual se pone en duda la legitimidad de su derecho a servicios de salud. Se argumenta, sin embargo, que hay poca base empírica para esta idea.

Al mismo tiempo, contribuye a debates más amplios sobre la exclusión social y el universalismo. Se analizan los procesos institucionales de exclusión, que toman forma en reacciones restrictivas del estado con respecto a la inclusión de migrantes. Si bien en discurso el estado puede reconocer la importancia de marcos de derechos humanos, en la práctica encuentra maneras inventivas para restringir el acceso de migrantes a los servicios sociales, dándole a las instituciones de salud un papel clave en la gestión de la migración. Seguidamente, se argumenta que este tipo de reacciones estatales correlacionan con las percepciones negativas sobre la migración, los derechos sociales de migrantes y su incidencia en los servicios sociales de funcionarios de instituciones cruciales para la inclusión de los migrantes. Sin embargo, estas percepciones no están respaldadas por datos empíricos.

Finalmente, la investigación reconoce la importancia de estudiar el acceso real a servicios sociales, más allá del reconocimiento formal de los derechos, y la necesidad de analizar en qué manera migrantes acceden a los servicios de salud. Para esto, basado en grupos focales y una encuesta nacional como parte de una estrategia de recolección de datos primarios, esta tesis pone énfasis en los factores que determinan el acceso al seguro social, los servicios de salud pública y la medicina pública de una persona migrante. Destaca que la regularización es una condición necesaria, pero no suficiente, para la integración social, cuestionando así la comprensión limitada del concepto de integración de parte del estado, que se centra exclusivamente en la regularización de los inmigrantes 'ilegales'. Más importante, sin embargo, la investigación muestra que el universalismo en la política social no aplica por igual a nacionales y migrantes, y es, de hecho, estratificado.

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PREFACE

Nicaraguan migration to Costa Rica is one of the most prominent cases of South-South human mobility in Latin America. About 7% of the Costa Rican population has a Nicaraguan background and an important number of parents of new Costa Rican generations were born in Nicaragua. These tendencies acquire more relevance given the decline of the fertility rate and the increase of life expectancy among Costa Ricans. These transitions, along with other economic and social changes, produce a number of anxieties regarding the ways in which national belonging and nationhood are lived in Costa Rica. Indeed, the sense of Costa Rican nationhood has largely been imagined through representing Nicaraguans as the "other". In recent decades, the decline of public services, such as education, housing or health provision, has generally been justified as a consequence of Nicaraguan immigration.

Koen Voorend's PhD dissertation addresses to what extent Costa Rica's public health system attracts Nicaraguans immigration and whether there is any truth to the claim that migration is to blame for the decline in social service provision. The research is organized as a series of inquiries. The empirical chapters are contextualized by an analysis of recent changes in immigration law and the ensuing consequences regarding migrants' access to health provision, the most important of which being the requisite of affiliation to the public health system for applying for a residence (Chapters 2 and 3).

The thesis then explores Costa Rican perceptions of immigration, the prejudices that emerge and conform a sort of common sense racism (Chapters 4 and 5). These perceptions are subsequently contrasted with official figures on the demand of health services by the Nicaraguan community in Costa Rica. Among young populations, as usually is the case of migrants, the use of health provision is not as high as mainstream views suggest. The next two chapters (6 and 7) explore how Nicaraguans cope with

the difficulties they face when accessing public health provision. The chapters underline that paying for private services is a shared experience on both sides of the border. Chapter seven reports data from a survey carried out among Nicaraguan migrants and nationals in Costa Rica. This survey addressed the use of social services and representations about such use among both populations. The lack of jobs in Nicaragua and wage differentials emerge as the main reasons to migrate to Costa Rica. In contrast, public health provision in Costa Rica constitute a motive to migrate for only a very tiny percentage of the sample. Interestingly, reported health insurance through paid work by Costa Ricans and Nicaraguans is almost the same (19% and 18.8%, respectively), which adds evidence that Nicaraguans are not a drain of health public resources. These figures are similar to those reported by the latest Costa Rican Census (2011).

The next chapter (8) deploys a sophisticated set of statistical techniques to examine migrants' access to public health provision. One of the main conclusions of this chapter is that "There is strong statistical evidence that the migratory status variables are important determinants of the probability of being insured" (p. 185). This conclusion is highly relevant both for the definition of advocacy priorities by NGOs as well as for policy makers. The results suggest that Costa Rica's current migration law neither stimulates regularization nor enhances migrant integration and underscore the impending recognition that an immigration law reform is imperative.

This thesis will be of interest to those working on immigration and social policy but it will also be of interest to those who are designing their own methodological routes. Mixed methodologies and techniques are among the main qualities of this thesis. The qualitative/quantitative divide, which too often is still in place in academia, is constantly undermined throughout this thesis, showing that research benefits from different ways of working and diverse avenues of inquiry. Because the research question is a highly disputed topic, the choice of mixed methods translates into a strong contribution in an attempt to interlink reliability and validity with the challenge to meet social needs of knowledge.

Overall, the reading of this thesis deepens the understanding of the interplay between public health and immigration in Costa Rica. Importantly, taking "advantage" of health provision is not an important reason to emigrate to Costa Rica nor is the provision of public health services to Nicaraguans a main reason for the economic crisis experienced by the country's public healthcare institution, the *Caja Costarricense del Seguro Social*, in recent years.

Having said that, a remaining question is why, despite such evidence, the representation of Nicaraguan migrants is still associated with being a "drain" on public resources. Elsewhere, I have argued that the 'nation' has replaced 'society' as the framework through which sense is made of institutional change in Costa Rica (Sandoval, 2013).

This nationalized frame is taken for granted and is hardly discussed, but is problematic because it does not stimulate integration and solidarity. Subverting the frames through which immigration is represented is therefore an urgent task.

The prevailing understanding represent immigration as a "burden" and a "cost", especially related to social service provision, healthcare being a case in point as this thesis convincingly shows. A potential emerging shift in such framing would drive analysis, debate, and policy making to focus on "benefits" instead of "costs". Until now, Costa Rican society doesn't know much about the contribution of Nicaraguan migrants to the economy. While there is fierce debate on the "draining" of the public sector, it is scarcely recognized that Nicaraguan migrants are indispensable for the agro-based export economy (coffee, bananas, melon, pine apple, among others) so prevalent in rural areas or for the private security, construction and paid domestic work sectors in urban areas. How much migrants contribute to Gross Domestic Product is still a pending question. For Costa Ricans, answers to this question could potentially rock mainstream views that are not concerned with the economy's dependency on migrant labour. Those who are considered disposable and unwanted are actually indispensable for the prevailing style of development.

Theoretical and empirically informed research is needed to foreground interdependence between migrants and host societies, in this case between Nicaraguans and Costa Rican society. Koen Voorend's thesis illuminates ways of working toward new research questions.

Carlos Sandoval

INTRODUCTION

Crowded classrooms, understaffed public schools and an overworked and underfunded health system point to the strains on Costa Rica's public services. Since the 1980s, the country's 'exceptional' social policy regime has come under pressure as the country cut back on public social expenditure following the 1980s debt crisis, and ensuing structural economic and social transformations (Martínez Franzoni and Sánchez-Ancochea, 2013). In this context, the incorporation of Nicaraguan migrants, especially, in Costa Rica's welfare arrangements has become a particularly thorny issue (López, 2012; Sandoval, 2012, 2007; Campos and Tristan, 2009; Bonilla-Carrión, 2007).

This research analyses the interplay between migration and social policy in Costa Rica and the relationship between migrants and social services, specifically healthcare. Importantly, one of its principle contributions is empirical. It engages with a public policy debate in the country centred on the idea that Costa Rican health services constitute a welfare magnet for Nicaraguan migration, through which the legitimacy of their claim to health services is questioned. This thesis not only questions this idea but argues that it is rooted in public perceptions and narratives owing to a lack of empirical foundation. This underscores the importance of understanding the empirics behind welfare magnet arguments. Such arguments, furthermore, contribute to similar, also often empirically unfounded, debates in Europe and the US that undergird many anti-immigrant discourses.

While its theoretical aims are more modest, this research adds to a growing body of literature on the nexus between migration and social policy both in the North and the South and speaks to several broader theoretical and policy debates. Firstly, it analyses the social exclusion of migrants, and the mechanisms of extension (or denial) of their social rights in countries in the South. Of particular interest is the analysis of

state reactions, and the centrality of social and migration policy in such reactions, to migrant inclusion in more informal contexts of globalization. Second, it highlights the need to go beyond legal analyses of migrants' social rights and eligibility criteria and to focus on actual access to social services arguing that such access, as opposed to inclusive political discourse, or legal recognition of rights, is what really matters for migrant inclusion. Third, this research speaks to larger debates on universalism in social policy (in Latin America), arguing paradoxically that universal social policy is stratified and weaker for migrants because of institutional and (extra-)legal mechanisms of exclusion (discussed in Chapter 3).

Costa Rica is an ideal case in the South to study the migration-social policy nexus because it is the only country in Latin America that combines a robust universal social policy regime with high levels of net immigration[1]. Therefore, for Costa Rica, the important question of whether, how, and to what extent, migrants are to be included in welfare arrangements is a more pressing issue than in most of Latin America. Simultaneously, because of this 'exceptional' situation, Costa Rica is close enough of a case to speak to the literature on migration and social policy in the North. It thus provides a unique opportunity to critically assess this literature based on an experience from the South.

In Costa Rica, migrants' claim to the country's universal welfare benefits has been increasingly contested (Sandoval, 2007) in a context of weakening public social policy provision. While Costa Rica's welfare structures have remained very similar to those before the 1980s debt crisis, meaning that most programs and social institutions still exist, there has been a "growing tension due to the need to do more with less per capita resources" (Martínez Franzoni and Sánchez-Ancochea, 2012: 90). As a result, public social services have deteriorated in quality, while demand and supply of private services have flourished.

A telling case is the healthcare sector. Cutbacks in basic supplies were the essence of reforms of the 1980s and 90s, which resulted in increases in waiting time and lists and patient dissatisfaction (Martínez Franzoni and Sánchez-Ancochea, 2013). Indicative of this has been the development of per capita public social expenditure dedicated to healthcare, which almost doubled between the early 70s and the late 70s (from US $ 100 to 200, measured in US $ of 2000), but then decreased in the early 80s back to about US $ 120 and stagnated there until well into the 2000s[2]. In real terms, this implied a reduction in spending, which until now has not significantly affected the available mortality or morbidity indicators. However, there are signs of the effects this has had on healthcare provision. For example, health insurance coverage among salaried workers was highest at just under 80% before the crisis, but declined through the 80s and 90s to around 65% in 2005 (*idem*). Between 2000 and 2013, the number of

doctors per 1,000 inhabitants has fallen from 1.33 to 1.11 (CEPALSTAT, 2016). More importantly, mostly qualitative work has shown waiting lists for doctor appointments and specialized medical attention are longer and there is a growing dissatisfaction with healthcare services (Dobles *et al.*, 2013; Martínez Franzoni, 2004).

Further indicative of the erosion of the universal public health system is the increase in private provision of healthcare. Where public healthcare spending grew annually at 5% between 1991 and 2001, private spending increased by 8% on average (Picado, Acuña and Santacruz, 2003). Between 2000 and 2009, the share of private healthcare spending (composed of out-of-pocket expenditures and private insurance expenditures) in total healthcare spending increased from 23% to 33% (Martínez Franzoni and Sánchez-Ancochea, 2013), mostly driven by the middle and upper-middle income groups.

The deterioration of public services and cutbacks in public investment "are usually represented not as a consequence of neoliberal policies, but as a result of Nicaraguans' migration to Costa Rica" (Sandoval, 2004: 444). While migration flows from Nicaragua to Costa Rica have a long history (Cortés, 2008), immigration peaked in the 90s, just when Costa Rica was adopting new measures of economic liberalization in the aftermath of the 1980s debt-crisis. Indeed, labour migration, understood as cross-border movements with the purpose of getting a paid job in the destination country, represented another main trait of the structural economic transformations of this period in the Central American region. Between 1984 and 2000, the immigrant population in Costa Rica grew at an average annual rate of 7.5%, most of it explained by the influx of Nicaraguans (INEC, 1984, 2000)[3]. Between 2000-2011, the migrant population in Costa Rica still grew annually by 2.4% on average (INEC, 2000, 2011). Together with the United States, Costa Rica represented the main destination (Baumeister, Fernández and Acuña, 2008) for the 40,000 Nicaraguans[4] who migrated annually between 2005 and 2010 (United Nations, 2009). Census data from 2011 (INEC, 2011) show that migrants represented 9% of the total population. Nicaraguans currently make up 75% of the migrant Costa Rican population, that is, 6.7% of total population[5].

In this context of high immigration at a time social services are under pressure, the incorporation of Nicaraguan migrants in Costa Rica's welfare arrangements has been anything but straightforward. Voices of *welfare chauvinism*[6] are common in the country. There are persistent perceptions that Nicaraguan migrants displace nationals in the labour market (Voorend and Robles Rivera, 2011), are responsible for higher crime rates (Sandoval, 2012) and are to blame for the general demise of public social services (Dobles *et al.*, 2013; Goldade, 2009; González and Varela, 2003), particularly the country's emblematic social security and healthcare institution, the *Caja Costarricense del Seguro Social* (CCSS) (Voorend, 2013, 2014; Goldade, 2009;

Bonilla-Carrión, 2007). Amongst at least three quarters of the Costa Rican population there is a tenacious belief that migrants pose a risk to the country's social security (González and Varela, 2003), Costa Ricans perceive that Nicaraguans are more likely to make use of public social services as a result of their lower social levels and their 'illegality' (Bonilla-Carrión, 2007: 146), and are assumed to be overrepresented as users of these services, especially healthcare (Voorend, 2013). As such, anti-migrant hostility "has been the raw material of the exclusionary fantasies of the nation" (Sandoval 2012: 221).

Two recent developments have added to the already existing tensions. First, the international financial crisis that erupted in 2008 slowed down Costa Rica's economy, leading almost immediately to a rise in the unemployment rate from 4.9% to 7.8% between 2008 and 2009 (Voorend and Robles Rivera, 2011), reaching 8.5% in 2013 (INEC, 2013), and 9.2% at the end of 2015 (INEC, 2015). Second, in 2011, the CCSS found itself in a financial crisis that has put in question the sustainability of the institution (Carrillo *et al.*, 2011). In 2009, the first signs of CCSS's financial problems emerged, partially induced by the international financial crisis. In real terms, Costa Rica's gross domestic product (GDP) fell by 1.3%, which accounted for a fiscal deficit of -4% and -5% in 2009 and 2010, respectively (PAHO, 2011). Given that the CCSS is assigned 11% of GDP (7% healthcare, and 4% pensions), the crisis directly impacted the CCSS's income. On the more structural causes of the crisis, however, recent studies highlight an increase in payroll costs, corruption and mismanagement (Mora, 2015; Jaramillo, 2013; PAHO, 2011; Carrillo *et al.*, 2011). As a result, the financial situation of the CCSS quickly deteriorated, between 2009 and 2011, when the problem came out in public. OPS (2011) projected that without counteractive measures, the financial deficit could amount to US $ 600 million in 2015, about 11% of total planned expenditure. In the years that followed, the CCSS's reaction was to strictly enforce its laws to ensure only insured patients receive attention (see Chapter 3) and to cut medical provisions. However, in June 2016, Juliana Martínez Franzoni, one of the experts appointed to analyse the CCSS's financial situation and propose counter measures (Carrillo *et al.*, 2011) lashed out and pointed out the CCSS's unwillingness to make changes in its management. She argued that since the measures taken only marginally alleviated the financial pressure, the crisis had been aggravated and negatively affected the quality of service provision for those in need of medical attention (Lara, 2016).

Despite such analyses, the CCSS's financial difficulties are generally perceived to be related to migrants' demand for healthcare services (Dobles *et al.*, 2013). Fuelled by negative media coverage (Campos and Tristan, 2009; Solís, 2009; Sandoval, 2007; González and Horbaty, 2005), many Costa Ricans consider migrants directly to blame for the 2011 social security crisis (Dobles *et al.*, 2013; Sandoval, 2012). The persistence

of such perceptions is related to the lack of credible information on how and to what extent Nicaraguan migrants access social services.

In light of this situation, does the state resort to limiting newcomers' access to state resources, or is it bound by international human rights laws that ensure their social integration and equal social rights? What are migrants' social rights, and what is their actual access to social services? In other words, what is the extent of the *implementation deficit*, the difference between formal rights and their implementation (Soysal, 1994: 134)? How do Nicaraguan migrants access social services, and how are these incorporated in their welfare strategies? Which factors explain why some migrants gain access to social services while others do not? These specific questions relate to the social inclusion of Nicaraguan migrants in Costa Rica, understood here as their access to social rights, and their actual incorporation into social services.

At the same time, these questions engage with a broad and growing literature on migration, welfare regimes and social policy in the Global North, especially from Europe. A vast body of literature has focused on the extension of social rights for migrants (Van Hooren, 2011; Wilkinson and Graig, 2011; Schierup *et al.*, 2006; Baldwin-Edwards, 2002; Kofman *et al.*, 2000; Bommes and Geddes, 2000; Joppke, 1999; Faist, 1998; Soysal, 1994) comparing migration policy and the different types of integration, or membership, regimes (Lucassen, 2016; Papadopoulos, 2011; Castles and Miller, 2009). Generally, this literature comparatively assesses differences in welfare status (poverty, employment, social benefits) between migrants and nationals in different countries (Zrinščak, 2011; Carmel *et al.*, 2011; Koopmans, 2010; Castles and Miller, 2009), and points to the existence of intra-regime variations with regard to migrant integration (Freeman and Mirilovic, 2016; Castles and Miller, 2009; Banting and Kymlicka, 2006; Morissens and Sainsbury, 2005; Kofman *et al.*, 2000; Faist, 1995; Williams, 1995; Baldwin-Edwards and Schain, 1994; Heinelt, 1993). This literature also assesses migration's impact on the financial, social and political stability of social policy arrangements focusing on the question of how increasing diversity and multicultural influences affect solidarity for and the sustainability of the welfare state. The debate here is on the trade-off between diversity and solidarity, under the assumption that immigration undermines the societal legitimacy base for a comprehensive and solidaristic welfare state (Freeman and Mirilovic, 2016; Facchini, Mayda and Murard, 2016; Crepaz, 2016; Soroka, Harrel, Iyengar, 2016, Van Oorschot, 2008; Banting and Kymlicka, 2006). More recently, this literature has also focused on state reactions to migrant integration in light of growing security concerns in Europe (Lahav and Perliger, 2016; Carmel, 2011; Caponio and Graziano, 2011).

Some important contributions from the US literature focused on welfare migration, or the welfare magnet argument (Giulietti and Wahba, 2012; De Giorgi and

Pellizzari, 2009; Fiva, 2009; Van Oorschot, 2008; Muenz and Fassmann, 2004; Boeri, Hanson and McCormick, 2002; Borjas and Hilton, 1995; Borjas, 1994). These contributions focus on the question whether migrants chose their destination based on welfare benefits and whether they cluster in countries or states with higher benefits. Since the results generally do not provide conclusive evidence, the debate remains ongoing (Giulietti and Wahba, 2012; Van Oorschot, 2008).

Unfortunately, literature on migrant incorporation in welfare arrangements from the South is less abundant (Hujo and Piper, 2010), possibly because in the wake of the structural adjustment period, developing countries' social protection systems have become increasingly strained (Noy, 2013; Huben and Stephens, 2012). As a result, countries in the South have struggled to extend their welfare arrangements to encompass all citizens, let alone migrants (Martínez Franzoni, 2008; Baganha, 2000). Yet, there has been significant and growing interest in social policy in Latin American countries (as in other developing countries), especially for universalism (Martínez Franzoni and Sánchez-Ancochea, 2014; Pribble, 2014, 2008; Filguiera, 2014; Cecchini and Martínez, 2011; Cruz-Martínez, 2011; Haggard and Kaufman, 2008). This literature discusses the challenges for creating universal social policy and extending coverage and its benefits vis-à-vis targeted social policy but hardly contemplates migration and migrants.

In the relevant international migration literature from Latin America, there are rich discussions on migration policy, especially in important destination countries like Argentina (Begala, 2012; Torres, 2012; Ceriani Cernadas, 2011; Domenech, 2011; Cerrutti, 2011; Courtis *et al.*, 2010; Courtis and Pacecca, 2007; Giustiniani, 2004) and Chile (Douchez-Lortet, 2013; Cabieses *et al.*, 2012; Doña-Reveco and Levinson, 2012, Stefoni, 2011). Generally, social policy is not a central focus, but these contributions have analysed the implications of migration policy and reform for migrants' legal access to social policy.

However, this literature, just like in the North, has focused on social policy eligibility. That is, social rights have been discussed mostly in terms of formal entitlements, not real access to services (Pribble, 2015; Morissens, 2008; Sainsbury, 2006; Morissens and Sainsbury, 2005). This translates into a void in the literature regarding the concrete ways in which migrants interact with social policy, how social services are integrated in welfare strategies and how migration and (universal) social policy interact. While the difference between entitlements and actual access to social services is important in the North, arguably analyses are more pressing in the South because labour market contexts are more informal (Barrientos, 2004), institutional capacity is weaker (Baganha, 2000), and social policy regimes less encompassing and more stratified (Noy, 2013; Martínez Franzoni, 2008; Barba, 2007).

In attempt to fill this gap, this thesis analyses different dimensions of the interplay between migration and social policy. Specifically, it focuses on public health insurance and the provision of and access to public healthcare services in Costa Rica. This decision is motivated by several considerations. First, because the healthcare sector is the flagship of Costa Rica's universal social policy regime. The focus is on the CCSS, or commonly known as the '*Caja*', for its central importance in public healthcare provision. Second, unlike pensions or basic education, healthcare is required throughout a person's life, and unlike family transfers or other focalized social services, it is required across class, race and ethnicity. Third, because healthcare implies a day-to-day interaction between migrant populations and the state, migrant incidence is most visible in this sector. Fourth, and because of this, it is here where the tension between migration and social policy is most obvious. Indeed, Goldade (2011) argues that in healthcare, because of the *ius soli* or birth right citizenship model[7], the struggle over inclusion in the Costa Rican state is most obvious. Finally, given the CCSS's financial difficulties, migrant claims to health services have become even more polemic.

Methodologically, the research combines quantitative and qualitative research techniques. In each chapter, the methodologies that serve that specific section are explained in more detail. Chapters two and three draw from documentary research, including critical readings of legal frameworks and migration reforms. In Chapters three, four, and five, the reading of legal documents and existing literature to identify state reactions to contemporary migration to Costa Rica complements information from interviews with policymakers, social service providers and office clerks, as well as NGO officials and academics, to understand accounts of people involved in the creation and daily execution of policy. Chapter five also draws from institutional quantitative data on migrant incidence in health services. Chapter six is exclusively based on qualitative data, specifically Focus Group Discussions (FGDs), to understand anecdotal accounts of migrants with regards to their experiences in accessing Costa Rica's social services. Finally, Chapter seven and eight draw from primary survey data. A survey of 795 respondents covered Nicaraguan migrants (N=394) and Costa Ricans (N=401) in similar socio-economic conditions. It provides important information regarding the factors explaining migrants' access to social services.

Beyond the introduction and conclusion, the thesis consists of eight chapters. The first chapter sets the stage by laying out some general theoretical considerations and justifying Costa Rica as a case study. It is called: 'Studying Migration and Social Policy (in Costa Rica): Theory and Justification'. Chapter two, titled 'Migration Policy and Eligibility Criteria for Access to Costa Rica's Healthcare Services', provides a brief contemporary history of migration policy in Costa Rica, focusing especially on the period after the 1980s, to better understand the context in which the present-day

tensions and claims for welfare restrictions are embedded. It then introduces the Costa Rican healthcare system, the eligibility criteria for access to healthcare services and what these two imply for (Nicaraguan) migrants.

The third chapter, titled 'Shifting State Sovereignty: The Interplay between Social and Migration Policy in Costa Rica',[8] analyses the way social and migration policy interact. It is argued that in response to economic slowdown and the CCSS's financial crises, Costa Rica has taken measures to limit migrant's access to health insurance and consequently healthcare services. This contrasts strongly with the more inclusive human rights vocabulary that recent migration reform boasts, and shows not only the inventiveness of the state to circumvent international normative constraints, but also that the state is a complex and often contradictory institution. This is especially true when it comes to specific sectoral policies such as public healthcare.

Chapters four and five critically analyse perceptions and realities of Costa Rica as a welfare magnet, contrasting the perceptions among (social) policy makers and providers of health services with the data on the 'real' incidence of migrants in the coverage of these services. Chapter four, titled 'From the Frying Pan into the Fire. Perceptions of Costa Rica as a Welfare Magnet in the context of a Social Security Crisis'[9], discusses the persistent idea amongst Costa Rican policy makers and service providers that Costa Rica is a welfare magnet and that its social policy regime has stimulated migration inflows from Nicaragua. For this, the chapter analyses narratives of CCSS policy makers and senior migration officials, as well as the narratives of officials of both institutions who work at an operational level.

The fifth chapter, titled 'Social Services as a Magnet? The Incidence of Migrants in Health Services'[10], contrasts these perceptions with institutional data on the incidence of (Nicaraguan) migrants in healthcare services, based on an incidence analysis. It suggests that the perceptions discussed previously are not necessarily backed by the empirical data their own institutions provide or, at best, have only very weak empirical foundation.

The sixth chapter is based on qualitative work with Nicaraguan migrants in Costa Rica, and is called 'Sidestepping the State. Private Practices of Health Provision among Nicaraguans'. It is shown how Nicaraguans on both sides of the border adopt very similar commodified practices of healthcare strategies. In Costa Rica, access to public healthcare is limited by legal and extra-legal mechanisms, while in Nicaragua the state provides very few and qualitatively insufficient services to cover the whole population. As a result, the market is sought for access to such services.

Chapters seven and eight introduce analyses of primary survey data collected among Nicaraguan migrants to assess their actual access to Costa Rica's social services, and how these feature in their welfare strategies. Chapter seven, called 'Migrants'

Stratified Access to Public Healthcare', presents descriptive statistics and means test analysis to understand differences in access to public health services between Costa Rican nationals and Nicaraguan immigrants, and Nicaraguan immigrants with different migratory characteristics.

The eighth and final chapter is titled 'From Social Rights to Access. Factors explaining Migrants' Access to Healthcare Services', uses statistical analysis to understand which factors explain why migrants access health insurance and health services and why others don't. As such, the chapter assesses the relative importance of (regular) migratory status, exposure to the host society, education, labour insertion and family composition, among others.

The concluding chapter discusses the various findings in light of the country's specific public policy debate, as well as larger discussions on the mechanisms of exclusion, and universalism in social policy reviewing the implications of the case for our understanding of how migration and social policy interact in a development context in the Global South.

Notes

1 In Argentina, the migrant 'stock' represented 4.5% of total population, while Chile is still a net emigration country, but 3% of its population is immigrant (Noy and Voorend, 2015). Most of this migration is from neighbouring countries. However, the flows of migration in relative terms are substantially lower than in Costa Rica, and their social policy regimes are more stratified, and much more dependent on market-mechanisms of social protection (Martínez Franzoni, 2008).

2 Martínez and Sánchez-Ancochea (2013) present the data in Costa Rican colones of 2000, which were converted at a rate of 1 US $ = 500 colones, for simplicity's sake.

3 While Costa Rica is a net-immigration country, this should not hide the fact that it also has significant migration outflows, especially to the United States (Caamaño, 2011).

4 This refers to average annual net migration between 2005-2010, defined as "The annual number of immigrants minus emigrants, generally estimated indirectly from overall population change not of natural increase" (UN, 2009).

5 However, this figure does not include the entirety of an unknown share of irregular migrants who are active in informal labour markets.

6 Welfare chauvinism reflects the fear amongst native populations that new immigrants take away jobs and social services (Faist, 1994) and can translate into a more restrictive benefit policy, denying immigrants access to social benefits, and a more restrictive immigration policy, denying foreigners the right to stay in the country and restricting their access to comprehensive social programs (Banting, 2000).

7 The *ius soli* citizenship model gives citizenship rights to any person born in the territory of the state.

8 This chapter has been published as a journal article in *Transnational Social Review* (2014: DOI: 10.1080/21931674.2014.952977).

9 This chapter is an improved version of a Spanish journal publication, co-authored with Karla Venegas Bermúdez, in Revista de Ciencias Sociales [2014, "Tras de cuernos palos. Percepciones sobre Costa Rica como imán de bienestar en la crisis del Seguro Social", ISSN: 0482-5276].

10 This chapter builds upon a chapter with a similar title, written in Spanish and published in an edited volume by Dr. Carlos Sandoval, on Migrations in Central America: Politics, territories, actors [*Migraciones en América Central. Políticas, territorios y actores.* 2016. San José: Editorial UCR].

CHAPTER 1

Studying Migration and Social Policy (in Costa Rica): Theory and Justification

1.1 Introduction

Globally, South-South migration is almost as large as South-North migration (Hujo and Piper, 2010). World Bank research has shown that migration between developing countries makes up for a substantial share of total international migration. Of the migrants from developing countries, Ratha and Shaw (2007) estimate nearly half, or 74 million, reside in countries in the South. However, this number is probably higher because irregular migration is unlikely to be completely accounted for in most national data. Almost 80 percent of these South-South flows take place between neighbouring countries, and of total remittance flows, South-South remittances are estimated to account for anywhere between 10 and 30%.

Shorter distances between countries, networks and closer cultural ties as well as refugee streams and transit migration account for the importance of South-South migration. Additionally, middle income countries in the South attract migrants from nearby low-income countries because of wage differences (Hujo and Piper, 2010). The region of Latin America and the Caribbean has a relatively low intraregional migration, and only 14% of international migrants born in Latin America currently residing there (United Nations, 2012). Yet, some important migration networks are located in the region.

Compared to other Latin American countries with well-established (albeit quite different and more stratified) social policy regimes, like Argentina, Chile and Uruguay, Costa Rica, for example, has a far larger migrant share in its total population, as shown in Table 1. In all four countries, large shares of immigration flows come from other Latin American countries, often direct neighbours.

Table 1. *Migration Shares and Origin of Main Regional Migrant Populations for selected Latin American Countries, around 2011.*

Country	*Migrant Share in Total Population*	*Distribution of Foreign Born Population of Biggest Migrant Groups*
Costa Rica	9%	Nicaragua (75%) Colombia (4.3%) United States (4.2%) Panama (2.9%)
Argentina	4.5%	Paraguay (36%) Bolivia (24%) Chile (13%) Peru (11%)
Chile	3%	Peru (30%) Argentina (17%) Colombia (8%) Bolivia (7%) Ecuador (5%)
Uruguay	2.2%	Argentina (35%) Brasil (18%) Other S. American countries (15%) United States (10%) Central America (4%)

Source: Own elaboration based on data from INEC, 2011 (Costa Rica); INE, 2012 (Chile); INDEC, 2010 (Argentina) and INE, 2011; IOM, 2011 (Uruguay).

However, South-South migration in Latin America takes place in countries with and without well-established social policies (although the very notion of 'well-established' is relative). Mexico is an important transit and destination country for many Central American migrants (Sandoval, 2015), and the Dominican Republic, a country of about 10 million people from which many Dominicans migrate themselves, hosts a large population of Haitians: anywhere between 60,000 (World Bank Estimate) and 402,000 migrants (UN Migration Wall Chart estimate) (Middeldorp and Voorend, 2015).

Yet, for developing countries, the literature on how migration and social policy interact remains nascent (Hujo and Piper, 2010). The burgeoning literature on welfare regimes in the global South (c.f. for Latin America: Martínez Franzoni and Sánchez-Ancochea, 2013; Martínez Franzoni, 2008; Barba, 2007; Sandbrook *et al.*, 2007; Gough and Wood, 2004; Filgueira, 2004, 1998) has largely overlooked migrants'

rights and access to social policy in particular. Otherwise, most of the existing literature in Latin America linking migration and social policy focuses on social *rights*. This literature is more common for countries with important migration inflows and relatively strong social policy, like Argentina and Chile. It typically assesses migrants' legal entitlements and the formal recognition of their (social) rights in migration reform (cf. for Argentina and Chile: CELS, 2013; Begala, 2012; Torres, 2012; Novick, 2012, 2010, 2008; Domenech, 2011, 2008, 2007; Ceriani, 2011; Cerrutti, 2011; Courtis *et al.*, 2010; Carrasco, 2008; Courtis and Pacecca, 2007; Jelin, 2006; Asa and Ceriani, 2005; Varela, 2005; Giustiniani, 2004; Oteiza and Novick, 2000). However, there is still much to research on the way migration challenges social policy in the South, how states react to migrant demands for social services, whether migrants are in fact incorporated in welfare arrangements and the ways in which migrants negotiate citizenship and incorporate public social services in their welfare strategies

What makes the Costa Rican case compelling is that the country hosts the highest percentage of an immigrant population in Latin America, and in parallel, is one of few countries in the South with a strong universal and solidary social policy regime. In this sense, Costa Rica makes for a unique site in Latin America to study how and to what extent migrants are incorporated in welfare arrangements. This, in many ways, can also draw from the existing, mostly European, literature. Such literature is written for formal institutional contexts, and thus cannot be taken for granted for countries in the South, like Costa Rica, where labour markets are more informal and institutional capacity is weaker.

1.2 General Theoretical Considerations

This section introduces some of the critical debates in the academic literature that this research engages with, followed by a detailed discussion of the Costa Rican case.

1.2.1 Social Policy and Universalism (in Latin America)

The first debate this research engages with is about universalism in social policy (in the South), and it contributes by specifically adding migration to the equation. Social policy is understood as public interventions that have the objective to prevent people suffering losses in income and life opportunities, while actively promoting decent living and work conditions (Fischer, 2009; Mkandawire, 2005). Concurrently, social policy constitutes a set of fundamentally political exercises that define the institutional base of citizenship rights. Granting entitlements only to citizens is thus a principle

means by which states win the loyalty of their populations (Joppke, 1999). Social policy articulates one of the principle mechanisms of integration and segregation within societies (Fischer, 2009; 2012) and is consequently of crucial importance to migrant integration. It is therefore not surprising that the extension of social rights to migrants and their access to social services is often a contested issue. This is true in the North, but also, and because of weaker and less encompassing welfare arrangements, maybe even more so in the South (Baganha, 2000).

Social policy includes social services and social security, the latter having received the most attention in the literature of late (Fischer, 2012). Social security includes social protection or insurance, social assistance, standards and regulation, for example, within the labour market. This research engages more with the social services component of social policy, especially healthcare which, together with education, is key for migrant integration. Healthcare is of particular interest, not only because people may need these services throughout their whole life, but also because migrant presence is felt most in this social service. Healthcare structures thus affect the way different social groups and classes interact in moments when they are vulnerable.

The way in which people in general, but migrants in particular, come into contact with social services, depends much on the dominant paradigm behind the provision of social services. Several authors demonstrate the advantages of universalism over other social policy approaches, such as (means-tested) targeting (Martínez Franzoni and Sánchez-Ancochea, 2013; Fischer, 2012, 2009; Danson *et al.*, 2012). The former has been shown to have a greater impact on reducing poverty, vulnerability and inequality (Fischer, 2009; Mkandawire, 2005), while the latter "usually entrenches segmentation in provisioning systems, which in turn reinforces social and economic stratification by removing the middle class and their political voice from the services that are supplied to and accessed by the poor" (Fischer, 2009: 6). Indeed, because the middle class is eligible for welfare benefits, they are more willing to support universal social programs and their funding, even if these programs are specifically designed for alternate groups in society (Martínez Franzoni and Sánchez-Ancochea, 2013).

This cross-class alliance of the poor and middle class segments of society not only favours coverage but also the quality of the services provided (Mkandawire, 2005; Huber, 2002). Generally, the middle class can voice its political demands more strongly because it has more economic and political resources (Martínez Franzoni and Sánchez-Ancochea, 2014). The middle class has a vested interest in quality services for all, so long as they depend on such services for themselves and their families. People with very different income levels end up sharing similar treatment based on their status as citizens —the condition of eligibility. The *paradox of redistribution* (Korpi and Palme, 1998: 681) thus predicts that social policy regimes targeting the

poor are rendered less effective in reducing poverty and inequality than their universal counterparts (Martínez Franzoni and Sánchez-Ancochea, 2014; Fischer, 2009; Mkandawire, 2005).

Following this logic, universal social policy is expected to translate into larger coverage of migrant populations. Universalism, however, is a vague concept. Its basic concept, of equal treatment for all, is actually quite complicated in practice, especially in high inequality societies (Fischer, 2012). Indeed, universalism is, in and of itself, hardly a sufficient condition to ensure immigrants' access to social services. If eligibility criteria are based on the right of citizenship (Lister, 1990), this would exclude many of the migrant categories.

It is important to distinguish between universalism as the guiding principle behind social policy, granting social rights to all citizens, or universalism as the outcome of social policy, understood as complete coverage of a specified population (Anttonen *et al.*, 2012). Based on this distinction from Anttonen *et al.* (2012), this study uses universal(ism) and universalist(ic) differently. Universal or universalism, on the one hand, is understood as the guiding principle of equal right to social benefits based on the criteria of (social) citizenship, be it on the more exclusionary basis of (civil) citizenship, or the more inclusionary basis of *denizenship*. Denizens are people who are citizens of another country with a legal and permanent resident status (Hammar, 1990), but who, depending on the particular country, do not necessarily enjoy the full extent of social and political benefits that come with citizenship. On the other hand, when social policy covers (almost) the entire population for which it is designed, reference is made to universalist or universalistic policies. While the two concepts are intricately related, they are not the same. For example, Nicaragua's social policy on paper is based on the principle of universalism, but coverage rates of social services are in practice very low (Martínez Franzoni and Voorend, 2012). Similarly, when targeted social policy is designed in poor countries like El Salvador or Brasil (Martínez Franzoni and Sánchez-Ancochea, 2014), on such a scale that it covers large sections of the population, this (slow but steady) move towards more universalistic coverage of social services is not necessarily born from universalism as a principle. Consequently, while normally universalism is an important condition for universalist social services, it is not a sufficient nor necessary condition *per sé*.

Note that coverage is but one component of universalism. Similar to Martínez Franzoni and Sánchez Ancochea (2013), Fischer (2012) provides a useful decomposition of universalism, arguing that it is made up of three dimensions: access/coverage; price/costs; and financing. While this research is primarily (but not exclusively) concerned with the first of these dimensions, this conceptualization of universalism is powerful because it goes beyond the dichotomy of "universalism" vs. "not universalism". Each

of the three dimensions can be assessed, allowing for a universalism spectrum from strong to weak. It thus permits an assessment of whether the same universalism principles apply for migrants as for nationals, and if not or less so, which mechanisms drive this stratification.

The first dimension concerns access or coverage, which implies not only that all people access social services, but that they access these services without discrimination within the same institutions and organizations, and that the need for medical attention is the main criteria for triage, not the patient's means (Fischer, 2012). The distinction between private or public providers of social services is not as important here as is the regulation for equal access to such services. The strongest universalism, of course, has universalistic coverage.

The second dimension relates to how the costs and prices of social service provisioning are determined. Specifically, in universal social policy the pricing of service provisioning is normally decommodified, meaning that it does not depend on the market but on regulation. For example, users of health services do not usually pay the actual cost of the service, but a fraction of the costs, if anything at all. It is important to add to Fischer's dimension that here too the principle of equality is paramount, especially when addressing migrants' access to services. If nationals' pricing of social services is decommodified, and migrants' isn't, or is but to a lesser degree, the universalism principle is weakened.

The third dimension, with which this research engages only partially, concerns the modality of financing of social services. In policy regimes with strong universalism, financing is generally indirect (i.e. not at the time of need) through progressive forms of taxation. In contrast, in weak forms of universalism, financing takes place directly at the time of need, through forms of payment which are mostly regressive, such as out-of-pocket payments for health services (Fischer, 2012). Again, for this study, if there are significant and structural differences between groups of migrants and nationals with regard to the financing of the social services they access, universalism would apply to both groups differently.

In recent years, attention to universalism in social policy has intensified in Latin America and other parts of the periphery (see for example: Martínez Franzoni and Sánchez-Ancochea, 2014; Pribble, 2014; Filguiera, 2014; Cecchini and Martínez, 2011; Cruz-Martínez, 2011; Haggard and Kaufman, 2008). This debate has to a large extent been induced by the various conditional cash transfer programs operating in a number of Latin American countries, and has highlighted the challenge of extending coverage beyond means-tested provision of (basic) social services. While the focus has been mostly on coverage or what Martínez and Sánchez-Ancochea (2014: 2) call the *minimalist approach*, there is now a growing understanding that this approach is

too limited to create solid social policy programs. On the other hand, a *maximalist approach* which includes generous benefits based on the principle of equity, and financed through general taxes, might be overambitious in the South.

One of the main problems is dealing with the already existing segmentations in which "the urban middle class and some blue-collar workers enjoyed access to relatively generous systems of public protection, but peasants and informal-sector workers were generally excluded or underserved" (Haggard and Kaufman 2008: 1). Historically, these segmentations have been policy driven, as the state reinforced this segmentation by creating many different welfare categories, for example through special insurance and pension regimes. Later, the neoliberal induced *new social policy* paradigm (Molyneux, 2008) with an almost exclusive focus on targeted social benefits, only further deepened this segmentation. Namely, its initial focus was on coverage, not accounting for the quality and availability of social services (Martínez Franzoni and Sánchez-Ancochea, 2014).

In this context, social policy, in general, and universalism, in particular, have gained more centrality in the political debate in many Latin American countries. Partly driven by international ideas and growing state budgets, increasing with the commodity boom and democratic pressures (Martínez Franzoni and Sánchez-Ancochea, 2014: 19), social policies have extended coverage and means-tested benefits have been increasingly challenged by universalism. Broad coverage of CCT programs, for example, has led to the articulation of new social demands, reinforcing debates on universalism.

These debates have largely ignored migration and migrant populations. This is not altogether surprising. For most Latin American countries, the principle challenge is to create and/or fortify universal social policies that encompass the national population. In such scenarios, pressures and expectations to extend coverage to migrant populations may be much weaker, and resistance to do so from nationals stronger (Baganha, 2000). Theoretically, more migration leads to more diversity in society. In the case of many Latin American countries, and Costa Rica in particular, migrants are also generally poor and with little education (Sandoval, 2016; 2007; Morales and Castro, 2006). These two factors, in a context in which social policy is already under (financial) strain, may lead to increased erosion of universalism.

Therefore, especially in countries like Costa Rica with longer social policy traditions, the question of migrant incorporation into welfare arrangements is important. Relatively high migrant presence, along with normative reasons of equity and inclusion are important causal factors. They also inform us of the strength of universalism as a guiding principle behind social policy, and the limits of the (weakening) cross-class coalitions that form its basis. To start discussing these issues, this research incorporates

migration by assessing whether the principle of universalism applies equally to nationals and migrants.

1.2.2 On Exclusion, State Sovereignty and Migration

Social Exclusion

A second debate this research speaks to is the social exclusion of migrants, and whether states will grant migrants social rights or not. There is no consensus on the concept of social exclusion, specifically on whether it adds substantial conceptual and empirical value that sets it apart from debates on poverty. However, this research draws from a specific definition of social exclusion as a process of obstruction. Such processes can be induced by structural factors, institutional mechanisms or deliberate agency by individual actors (Fischer, 2011).

This definition is particularly useful to study migrant exclusions, as well as migration policy, as it goes beyond the analysis of a state or outcome of exclusion and rather places emphasis on which *mechanisms* cause the process of exclusion. First, by recognizing that structural factors, institutions and agency may cause exclusion, and that such exclusion can be the result of intentional and unintentional doing (Fischer, 2011). In Costa Rica, the structural demand for low skilled migrant labour and poor labour conditions in specific sectors, conditions the opportunities for migrant integration. At the same time, as will be shown in this research, institutions can unwittingly create mechanisms of exclusion for migrants. Migration policy with a deliberate policy focus on the regularization of migrants, for example, may in fact aggravate exclusionary processes for migrant integration if the criteria for this regularization does not match migrants' economic and social realities (for example, migrants' ability to pay for the necessary documentation). Similarly, more stringent law enforcement by migration and social policy institutions may enforce mechanisms of stratification between nationals and migrants if they create dissimilar conditions of access to social policy. Such forms of exclusion may be the result of good intentions to ensure formal labour relations, but in reality may produce the opposite.

If forms of exclusion, in contrast, are intentional, Fischer (2011:17) speaks of 'agentive' processes. These are deliberate forms or exclusion, such as identity-based discrimination, which are practiced by one actor against another. In the context of this research, this may happen when migrants are offered different conditions with regard to healthcare, either as a deliberate policy or because of personal discriminatory decisions of the people in charge of the provision of social services.

Second, exclusion is the result of repulsion from or the obstruction of access to certain resources, benefits or opportunities. Again, this repulsion or obstruction, may be either intentional or unintentional. In this context, if a migrant is denied access or receives poor quality health services, this can be considered social exclusion, if this is conditioned by some structural, institutional or agentive repulsion or obstruction.

The State and Inclusion

Existing approaches are divided on the question of whether states tend to be inclusive or exclusive towards migrants. In other words, do they grant migrant populations social rights (Baldwin-Edwards, 2002) or not, and if they do, to what extent? In the North, traditionally, states with generous benefits and low ethnic diversity were expected to be more reluctant in granting migrants access to benefits and transfers, preferring to preserve them for the national population (Faist, 1994; Esping-Andersen, 1990). However, empirical research does not find support for this claim (Morrisens, 2008; Banting, 2000). Migrants actually seem to be better-off in social-democratic welfare states, owing to universalism and generosity of social policy, easier access for newcomers to citizenship, and better access to welfare benefits for migrants (Van Hooren, 2011; Sainsbury, 2006; Hjerm, 2005; Banting, 2000; Baldwin-Edwards, 1991). In her analysis of Sweden, Germany and the US, Sainsbury (2006: 239) concludes that immigrants are granted more entitlements in encompassing welfare states than in liberal ones, which have generally been less-inclusive with regards to migrants (Banting, 2000). More encompassing social policies beyond contribution based benefits (Banting, 2000) makes it easier to access social services in the former countries, guaranteeing access to a minimum standard of living.

Faist (1996) agrees that the incentives to integrate migrants are higher for integral welfare states with high benefits and extensive social rights, especially when tax-financed, because failing to integrate them in the formal labour market comes at a high cost. He goes on to explain that this also accounts for the stronger backlash against migrants' claim on tax-financed benefits, and why these kinds of benefits are precisely those that have seen reforms and cutbacks in many European countries. He shows, however, that in liberal countries such as the US, with fewer regulations in the labour market, as a result of stronger *laissez-faire* traditions and weaker welfare state structures (Hollifield, 2000), migrants have fewer problems incorporating into the labour market. Yet, the same forces imply that migrants face higher risks of ending up in low-paid jobs and thereby experiencing economic deprivation. In countries with more comprehensive welfare states, migrants tend to find better jobs in comparison, but labour market entry may be more difficult (Faist, 1996).

Interestingly, the mechanisms of exclusion seem to work through the same dimensions as the principle mechanisms of inclusion to welfare arrangements. For Western Europe, Heinelt (1993) shows that immigrant exclusion works through status attributions by the state in social-democratic regimes, both through citizenship laws and status regulations in conservative welfare regimes along with market processes in liberal regimes (Heinelt, 1993). It becomes interesting to analyse the nature of these mechanisms. Those that are state-led through the definition of more inclusionary or exclusionary eligibility criteria, as well as those that function through the (labour) market by confining migrants to secondary, inferior and informal labour markets. Finally, mechanisms of exclusion may also be less formal, and relate to everyday practices of discrimination and xenophobia, both in public institutions in charge of social policy and in the labour market. Indeed, social policy can function as "a double-edged sword" (Hollifield, 2000: 109) It can expedite immigrant integration, but it can also be used as an efficient mechanism to exclude migrants from access and thereby condition their integration in society.

These findings provide somewhat contrasting predictions for Costa Rica. On the one hand, the country with one of the most encompassing social policy regimes in the developing world (Martínez Franzoni and Sánchez-Ancochea, 2013) could be expected to create favorable conditions for migrant integration. On the other hand, the fact that Costa Rica's labour market, like most in the South, is considerably more liberal-informal than most economies in the North (Martínez Franzoni, 2008; Gough and Wood, 2004; Barrientos, 2004), and that the social policy regime has been under strain, could mean that migrants are excluded from welfare arrangements. The crucial issue here, in line with Money (2010: 20) who argues for country case studies, is to analyse the Costa Rican case for the "difference in treatment of citizens and noncitizens [which] is the crucial measure of immigrant reception". Money (2010) contends that immigrants in liberal states enjoy fewer social rights, because citizens also do. Instead, what is of principle concern is whether immigrants are treated similarly or dissimilarly to citizens, and this is not directly correlated to the kind of welfare state in place.

Migration and State Sovereignty

A related ongoing debate this research engages with is on the actual degrees of freedom a state has to exclude migrants from welfare arrangements in a context of globalized normative constraints of human rights. Particularly, there is debate on the extent to which "developments subsumed under the term "globalization" have eroded national sovereignty [...] and international norms have constrained national policy making" (Guiraudon and Lahav, 2000: 163). Initially, Freeman (1986) argued that (welfare)

states are inevitably exclusive to secure and defend the social, political and economic rights of the privileged citizen, as well as access to (welfare) benefits. Implicit in this view is that states have the power and capacity to curb unwanted migration as well as setting and applying the rules of membership to the national polity.

Early globalist arguments (Favell, 2006; Sharma, 2006; Jacobsen, 1996; Soysal, 1994), however, saw migration as a "case of nation-states losing control" (Guiraudon and Lahav, 2000: 164). In this logic, economic globalization leads to increased capital, financial and labour mobility, and thereby decreases the power and importance of the nation state. In this scenario, globalist perspectives argued that international human rights regimes and migration challenged nation state sovereignty, thereby inducing a devaluation of the importance of citizenship (Sassen, 1996: 95). It was reasoned that citizenship is exercised and administered transnationally (Sharma, 2006; Soysal, 1994), as a result of the emergence of an "international human rights regime that prevents nation-states from deciding who can enter and leave their territory" (Guiraudon and Lahav, 2000: 164). Human rights are inalienable natural and legal rights based on personhood independent of nationality, in contrast to the national political, social and civil rights that are based on the distinction between domestic and foreign (Sassen, 1998, 1996). Thus, states are obliged to grant broad social rights to migrants living in their territory, becoming synonymous with citizenship (Baldwin-Edwards, 2002). Human rights agendas would then prevail over national attempts of exclusion to social rights.

This view was countered early on by authors who questioned the inevitable loss of state sovereignty versus transnational law (Sainsbury, 2006; Banting, 2000; Hollifield, 2000; Guiraudon and Lahav, 2000). Indeed, initial globalist arguments that argued that international norms would erode sovereignty, overlooked inventive state responses. Especially regarding migration control, states in the North maintain sovereignty in at least three ways, shifting the level at which policy is elaborated and implemented "up, down, and out" (Guiraudon and Lahav, 2000). Migration control is understood as the degree of a state's openness to immigration (Money, 2010), and the set of mechanisms it has at its disposal (to attempt) to deter, limit or stop migration flows.

Specifically, to counter or escape transnational normative constraints, states opt for more coordinated migration control at the international level (shifting up), decentralization of immigration policy to local levels (shifting down) and outsourcing of migration control functions to the private sector, by disciplining behavior that is not in accordance with immigration policy (shifting out) (Guiraudon and Lahav, 2000). In any case, more general projections from the globalisation literature, including more critical Marxist scholars such as Harris (2003), associate the decline of nation state

sovereignty not to global norms but to the inability of states to maintain control over capital and labour. That is, in the course of a broader retreat of the state, the state can still impose measures to control migration or install mechanisms of exclusion.

Given this literature is from the North, it is interesting to assess how countries in the South react to migration in light of such international normative frameworks, the increasing acknowledgment of migrants' social rights, and whether and to what extent such norms limit the state's degrees of freedom to exclude migrants from welfare arrangements. The question arises whether states in the Global South are similarly capable of circumventing international human rights as states in the North? In the context of transnational forces and economic globalization for public policymaking, and the prominence of transnational modes of citizenship in the literature, has the state or citizenship lost centrality regarding the extension of social rights?

Citizenship and "Illegality"

Through citizenship, national protection systems become political filters that condition migrants' efforts to realize their potential for social participation (Bommes and Geddes, 2000). If citizenship is understood as individual rights, participation and membership in different institutional spaces (López, 2012; Bauböck, 2007), it lies at the heart of "boundaries of inclusion and exclusion, which define both those who are full members of existing networks of reciprocity and deserve support, and those who are 'strangers' or 'others' to whom little is owed" (Banting, 2000: 13). It is important to note that these boundaries are not written in stone, but are constructed socially at different points in time, and in different institutional contexts (López, 2012).

However, there is debate on the centrality of citizenship as a criterion for social inclusion. Some suggest that it is not citizenship per se that matters when it comes to the extension of rights, but rather legal residence (Bauböck, 1995; Soysal, 1994). In such views, citizenship is being devalued by the rights that are attached to permanent residence. Others contend this is an oversimplification (Morris, 2002) and argue that citizenship is key to understanding migrant integration, for example looking at the denial of political rights (Morris, 2002: 20).

In any case, the diversified categories of membership in societies, defy "the citizen-alien dualism of either full or no membership at all" (Joppke, 1999: 6). Instead, a much more complex pattern is emerging, with dual citizenship, legal residents (without national citizenship) in some cases under specific cooperation agreements with other countries, other third country nationals, family reunification categories and probationary periods, asylum seekers and 'illegal' migrants complicating the panorama. These patterns translate into a continuum in terms of their associated rights.

Thus, membership in relation to a nation-state is not internally homogeneous, especially with regard to immigrants, and different memberships are related to different dynamics of social inclusion (López, 2012; Brubaker, 1992). Morris (2002) conceptualized these dynamics as civic stratification, leading to partial memberships. Immigrants are then often in an in-between category as *denizens* (Hammar, 1990), with regular status, but with limited political and social rights. Depending on the country's legal framework, denizens can have full or less-than-full access to social services, but are never accorded political rights. In such scenarios, denizens have to settle for a sort of incomplete citizenship that displays processes of civil stratification (Morris, 2002).

An extreme form of civic stratification is the exclusion of irregular immigrants, especially important for a developing country context, like in Costa Rica. Classified as 'illegals'[1] (or 'aliens'), these people live and work in the country without a legal migratory status and their presence in the host societies usually generates stern political controversy (López, 2012). They generally do not enjoy the basic rights associated with citizenship (Bosniak, 2000: 963).

Schierup *et al.* (2006: 41) argue that the systematic employment of undocumented labour represents an extreme form of differential exclusion, when states and state policy "accept or even create 'back doors' and 'side doors' for irregular migrants, [...] covertly exploiting the lack of rights and the vulnerability of these migrants". Morris (2002: 21) wonders whether "their illegal status should mean the denial of all rights, whether receiving states carry some responsibility for their presence and their treatment, or whether they stand completely outside any relationship with the state and therefore any protection". Social policy in particular is usually not designed for this group, and therefore difficult if not impossible to access. This gives the 'illegal' category a central importance when considering the possibilities for access to social services, and therefore social integration.

More recent contributions have questioned the centrality of 'illegality' for migrants' integration into society. Such contributions downplay the importance of 'illegality' (Kalir, 2013; Kyle and Siracusa, 2005; Agustín, 2003), and tend to conflate policy and political discourses around immigrant criminality and illegality. Concerned with not reducing immigrants to either 'criminals' or 'victims', they emphasize migrants' agency in circumventing exclusionary policy and argue that their migratory status is not a significant impediment to participation in a number of activities that encourage integration, for example, the labour market.

This research engages with such arguments analysing whether and to what extent state policies condition migrants' agency. Returning to the social exclusion debate, it is important to make a distinction between 'illegality' being 'just' a factor that conditions

migrant integration or whether 'illegality' is actively being used by the state as a strategy to generate exclusions.

1.2.3 Welfare Magnet and Welfare Chauvinism

A final debate with which this thesis engages is the welfare magnet or welfare migration literature. Broadly, this literature revolves around two related arguments, of which the latter is discussed in this thesis. The first set of arguments center on the idea that strong social policy regimes, with generous benefits and quality social services, attract migrants and serve as a welfare magnet. This literature is concerned with whether migrants choose their destination country as a function of the availability and generosity of social services (Van Oorschot, 2008; Menz, 2004; De Giorgi & Pellizzari, 2003; Borjas, 1999).

Second, along very similar lines, the welfare magnet literature focuses on whether migrants are disproportionately dependent on social provisions. Some country case studies have shown immigrants to be over-represented among users of unemployment, social assistance and family benefits (Van Oorschot, 2008; Muenz and Fassmann, 2004; Boeri, Hanson and McCormick, 2002; Borjas and Hilton, 1995; Borjas, 1994). For example, Borjas (1994) shows for the US that immigrants received a disproportionately high share of welfare cash benefits, and Borjas and Hilton (1995) show that the immigrant-native *welfare gap* is substantial and that immigrant households experience both more and longer welfare spells. This same literature discusses the relative economic costs and contributions of migrant integration in welfare arrangements.

The evidence, however, is not conclusive, and it is plagued with methodological issues. One such issue is the measurement of the direct and indirect economic contributions of migrants (Mojica, 2003), particularly those whom are largely employed in the informal sector. As Martínez Franzoni, Mora and Voorend (2009) have argued, much of Costa Rica's middle class economic activity, especially by women, is possible because of the availability of cheap Nicaraguan domestic labor, but that the value of such labour is hardly accounted. Indeed, an unconvinced Freeman (1986: 60) already noted three decades ago, "one is free to believe more or less what one wishes about the *economic impact* of migration because the facts are so much in dispute", something Van Oorschot (2008) seconded two decades later. What is of interest for this research is the idea that migrants may be overrepresented as beneficiaries of social services or social assistance.

Such ideas generally lie at the base of negative reactions to migration, which may lead to welfare chauvinism. While new non-threatening immigrant groups may be incorporated into social policy regimes without much difficulty (Banting, 2000), if

vulnerable sections of the host society voice concerns over the possible negative effects of immigration on welfare state arrangements, they might call for restrictions on immigrants' access to benefits even if they support the welfare state. This is what several authors call *welfare chauvinism* (Morrisens, 2008; Ryner, 2000; Banting, 2000; Faist, 1994; Soysal, 1994). Such reactions are common in times of economic crisis, especially but not exclusively in countries with liberal welfare arrangements (Morissens, 2008). Welfare chauvinism refers to the fear among native groups (as well as settled immigrants) that certain new immigrant groups take away jobs, housing and social services (Faist, 1994). It can take two forms: either it can translate into restrictive immigration policy, designed to prevent foreigners coming into the country and having access to comprehensive social programmes, or it may result in restrictive benefit policy, designed to deny resident foreigners access to social benefits (Banting, 2000). As such, in an attempt to 'defend' the welfare state, welfare chauvinism can result in the ethnicization of politics, giving rise to the "exclusion of selected groups of immigrants from social benefits who did not participate previously in the social security system" (Faist, 1994: 454).

If this happens at a time universal social policy is eroding and under strain, majority groups might lash out not only against immigration and multiculturalism, but also against the welfare state itself. This might result in "a more comprehensive neoliberal attack on the welfare state, contributing to the emergence of new radical right parties and/or the retreat of established parties from social redistribution" (Banting, 2000: 22).

1.3 Towards the Costa Rican Case

1.3.1 More Informal Contexts

Latin American countries, characterized by high levels of poverty and inequality (CEPAL, 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 with minimum levels of welfare extended to the entire population (Martínez Franzoni, 2008). Nonetheless, the continent hosts some of the longest traditions of social protection in the developing world (Huber and Stephens, 2012; Noy, 2013; Filgueira, 2004, 1998; Mesa-Lago, 1994). In the wake of the debt crisis of the 1980s and neoliberal policies of liberalization, deregulation and privatization in the decades that followed, these social protection systems have come under pressure (Huber and Stephens, 2012; Noy, 2012), and developing countries have struggled to extend their welfare arrangements to all citizens.

Perhaps more similar to countries in Southern Europe, migration to developing countries takes place in contexts of much weaker social policy regimes than in Northern Europe (Baganha, 2000). In countries where social policy does not cover the entire national population, and access to benefits is highly stratified like in most, if not all, developing countries, there is less fertile ground for social coalitions defending welfare institutions (Martínez Franzoni and Sánchez-Ancochea, 2013; Martínez Franzoni and Voorend, 2009; Korpi and Palme 1998). In such contexts, even if migrant rights should be legally recognized, "there is likely to be less pressure on the state to extend to immigrants social rights that pass from formal laws to everyday reality" (Baganha, 2000: 168).

Furthermore, the institutional scenarios in which migration occurs are very different in Europe. There, the first peak of contemporary migration took place during welfare capitalism's golden age between the mid-forties through seventies (Esping-Andersen, 1990), making migrant incorporation relatively easy[2]. There was little pressure on the financial sustainability of welfare benefits, and because existing institutions change only very slowly owing to path-dependency, short-term effects of migration on welfare arrangements were mitigated. Thus, native populations initially did not perceive immigrants as a threat to their own access to social benefits, and immigrants' social rights were not significantly contested from the start.

In this sense, in much of the South, migrant inclusion occurs in scenarios that look more like more recent migration flows in Europe, or to the US or Canada from the 1990s onwards, which met heavy institutional resistance to include migrants in more liberal social welfare arrangements. South-South migration to most receiving countries in Latin America[3] peaked in or after the 1990s. At that time, the already weaker existing social policy regimes were under significant strain during a period of structural adjustment and neoliberal reforms and pressure for cutbacks in social spending. At times in which the state is struggling to provide coverage and quality services for its population, immigrant's inclusion in welfare arrangements can be expected to be more contested.

However, unlike the US and Canada, labour markets in the South are not as effectively regulated and are less likely to create formal and well-remunerated jobs. In Canada, for example, much of migration occurs under bilateral worker programs, which create relatively formal labour conditions, albeit quite restrictive and heavily criticized by pro-migrant sectors of society (Hjalmarson, 2016). While the US struggles with 'illegal' migration, between 2005 and 2014, the unauthorized immigrant population levelled off at about 3.5% of total population (Krogstad and Passel, 2015). Taking into account that the US is one of the world's most important migration destination countries, particularly those hailing from Latin America, such levelling shows considerable institutional capacity for increased border control and restrictive migration

policy. In the South, such institutional capacity is usually weaker (Baganha, 2000). Therefore, considerable shares of migration in the South take place under irregular (or 'illegal') and informal conditions (Hujo and Piper, 2010).

This combination of different migration scenarios and institutional contexts has to be taken into account when studying migrants' social rights and access to social policy in the South for two reasons. Regular migratory status and formality are often among the eligibility criteria for access to welfare arrangements and thus form a significant barrier for migrants. More importantly, 'illegal' migration is often met with a significant political backlash (López, 2012) and therefore more likely to generate resistance among the national population, raising stronger voices for welfare exclusionism. This limits not only states' willingness but also their political degrees of freedom with regard to the recognition of migrants' social rights, and access to social protection. In summary, in a more informal and irregular migration context, the incorporation of immigrants into weaker welfare structures than in most advanced countries is not self-evident and needs to be scrutinized.

1.3.2 Costa Rican Social Policy

When its civil war ended in 1948, Costa Rica abolished its army and the political elite, and in a pre-emptive strategy to avoid the class struggle witnessed in Europe, decided to dedicate significant shares of national spending to social investments, principally at first to education and healthcare (Martínez Franzoni and Sánchez Ancochea, 2013). During the 1960s and 70s, there was considerable expansion of Costa Rica's welfare arrangements, including non-contributory benefits, and the state played a central role as a welfare provider and as an employer. At the peak of the state's influence, at the end of the 1970s, one in five Costa Ricans was employed in the public sector (Vega, 2000), in the country's national companies and state bureaucracy. Indeed, by that time, Costa Rica boasted practically universalist health insurance and medical services.

> Contributory insurance was mandatory for salaried and self-employed workers and reached all economically dependent family members. It was complemented by voluntary insurance for individuals with unpaid work such as housewives or students. Social assistance targeted the poor and individuals with serious disabilities. Medical services were standard for all, but illness and maternity subsidies were restricted to paid workers and were higher for waged than for non-waged workers (Martínez Franzoni and Ancochea, 2012: 90).

While the 1970s saw an expansion of public institutions, the 1980s was a decade of transformation, following the debt crisis of 1981 and the ensuing structural adjustment promoted by the Washington Consensus (Robinson, 2003). This resulted in trade

liberalization, financial deregulation and state retrenchment during the 1980s and 90s. These heralded a new economic model with a more diversified structure (Segovia, 2004), but also with unequal levels of dynamism amongst economic sectors resulting in unequal levels of market incorporation. As discussed earlier, structural adjustment policies led to pressures to cut back on social spending (Martínez Franzoni and Ancochea, 2013).

However, despite this pressure, currently Costa Rica still has one of the most robust social policy regimes in the continent (Martínez Franzoni, 2008). Costa Rica has high levels of per capita social spending compared to the Latin American and Central American average[4], and similar to other countries in the region with strong social policy regimes, like Chile, Argentina and Uruguay. It achieves this, however, with (much) lower levels of per capita national income (see Table 2). In 2012, per capita public social spending amounted US $ 1,293, similar to countries such as Chile and Panama, and not far behind Argentina and Uruguay.

Table 2. *GDP and Public Social Spending Per Capita for selected Latin American Countries, 2012. (In 2005 US $)*

Country	*GDP per capita*	*Public Social Spending per capita*	*As % of GDP per capita*
Argentina	6,854	1,893	27.6
Chile	9,453	1,340	14.2
Costa Rica	5,725	1,293	22.6
Uruguay	7,498	1,846	24.6
CA Average	2,068	244	11.8
LAC Average	5,798	870	15.0

Source: CEPAL (2013).

Costa Rica has a public education system that provides state funded preschool, primary and secondary education. This integrated public education system was constitutionally created in 1949. In the 1970s, primary education and up until the first cycle of secondary education was made compulsory. This system is led by the Higher Educational Council, under the umbrella of the Ministry of Education, which determines the curriculum (Martínez Franzoni and Sánchez-Ancochea, 2013). Currently, primary education provides practically universal coverage with around 92% of children enrolled in school. Coverage for secondary education, the sector that experienced the largest budget cuts in the 80s and 90s, is considerably lower at 73% (CEPAL, 2015).

Similarly, Costa Rica has an extensive, publicly provided healthcare system. 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 state with subsidies for the poor. The main provider of health services is the CCSS, which currently covers about 87% of the Costa Rican population through its health insurance. This insurance is paid through payroll taxes, but is also accessible for independent workers and voluntarily insured, for whom a progressive insurance premium is calculated depending on the reported occupation (see Chapter 2).

Nationally, just under 13% of the total population has no (public) health insurance. This group consists largely of agricultural labourers, informal sector workers, self-employed professionals and their dependents. The uninsured also use public health facilities, especially hospitals (Unger *et al.*, 2008; Clark, 2002).

The CCSS also administers the general, basic pension regime that is obligatory for any formal job. Costa Rica's multi-pillar pension system furthermore has a second obligatory complementary pension regime, and a private optional complementary regime, both of which are managed by financial institutions authorized by a supervising body, the Superintendence of Pensions. The fourth and final pillar is the non-contributive pension regime, which is managed by the CCSS with money from the Fund for Social Development and Family Allowances (FODESAF). This regime is designed for people living in poverty. Other social services include a variety of family allowances and social assistance programs managed by either FODESAF or the Mixed Institute of Social Assistance (IMAS), which are typically targeted programs for specific populations, mostly related to income poverty. Similarly, social housing programs and public housing subsidies are available if eligibility criteria are met.

Where Costa Rica distinguishes itself from other countries is the composition of social spending (Martínez Franzoni, 2008). Table 3 shows the structure of social spending for the period 2009-2010, compared to other countries with strong social policy regimes in the region. In countries such as Chile and Argentina, social policy emphasizes labour productivity and the market management of social risks, except for the poorest, for whom the state provides basic goods and services. The percentage of social spending for this kind of social assistance is considerably larger (around 45%) than in Costa Rica (28%), while Costa Rica dedicates a larger share to education (32%) and healthcare (29%). Indeed, in Costa Rica, the state provides social services to a much larger section of the population, including the middle class and the non-salaried population. This correlates to higher proportions of spending dedicated to the universal healthcare and education systems. The comparison with Central America deserves a note of caution. While the table might suggest a similar structure to that of Costa Rica, the levels of social spending in other Central America are substantially lower (cf. Table 1), social programs are scattered, have low coverage and have a very limited impact on income inequality (CEPAL, 2009; Martínez Franzoni, 2008).

Table 3. *Structure of Per Capita Public Social Spending for selected Latin American Countries, 2009-2010. (In percentages)*

Country	*Education*	*Healthcare*	*Social*	*Housing and Others*
Argentina	24	22	46	7
Chile	28	24	44	3
Costa Rica	32	29	28	11
Uruguay	17	22	48	13
CA Average	38	25	23	14
LAC Average	33	23	33	11

Source: Own elaboration based on CEPAL (2015).

All this has resulted in Costa Rica's remarkable comparative performance with regard to outcome and coverage indicators. Costa Rica has accomplished universalist and free primary education (although it has difficulty achieving this for secondary education), high rates of health insurance coverage, including for vulnerable and non-contributing groups, and is hailed as a healthcare "success story" (Noy, 2012), and a promising case of "health without wealth" (Noy, 2013).

For example, together with Cuba, it leads the ranks of life expectancy at birth for 2015 (79.6 years) in the whole of the Americas (CEPAL, 2013), not so far behind some of the most advanced North European countries like Norway (81.5 years), The Netherlands (81 years) and Germany (80.7 years) (HDR, 2014). Currently, a Costa Rican lives on average 6 years longer than any of his or her Central American counterparts. Similarly, the nation outperforms Argentina and Uruguay with regards to child mortality (see Table 4).

That said, as explained before, the 1980s heralded a period of structural reforms that resulted in cutbacks on social spending. This has put Costa Rica's social policy regime under strain, resulting in financial difficulties (PAHO, 2011), long waiting lines and more private healthcare spending (Martínez Franzoni and Sánchez-Ancochea, 2013).

1.3.3 Immigration in Costa Rica

At the time social policy came under pressure in the 80s and 90s, migration from Nicaragua to Costa Rica saw a spectacular increase (Voorend and Robles, 2011; Rosa, 2008; Sandoval, 2007; Segovia, 2004; Robinson, 2003). Before the 1990s, migration in Central America was mostly related to armed conflicts in the region, especially the Salvadorian Civil War (1980-1992), the Nicaraguan Sandinista Revolution (1978-79)

Table 4. *Outcome and Coverage Indicators for selected Latin American Countries, around 2013.*

	Education Enrolment (around 2013)		*Life Expectancy at Birth (2013)*	*Child Mortality Rate (2013)*	*Social Security Coverage (around 2010)*	*Pension Coverage (around 2010)*	*Health Insurance Coverage (2014)*		
Country	*Prim.*	*Sec.**	*In years*	*Per 1000*	*Contrib./EAP***	*Benef./ Pop. 65+*	*Total*	*Salaried*	*Non-salaried*
Argentina***	-	89.1	76.8	11.1	47.8	90.4	73.4	82.3	56.1
Chile	92.0	87.3	79.5	6.4	73.1	57.2	-	-	-
Costa Rica	90.0	73.3	79.6	8.5	66.5	41.0	87.1	91.1	77.8
Uruguay	72.0	72.0	77.8	13.8	66.8	85.7	98.3	99.3	95.4
CA Average**	77.8	50.9	73.2	19.3	23.3	13.2	-	-	-
LA Average	92.3	75.7	75.2	16.0	28.9	25.3	61.3	78.1	29.2

* Argentina: 2012; CA Average: 2011

** Chile, Costa Rica: 2009; CA Average, El Salvador and Honduras: 2009; Guatemala: 2006; Nicaragua: 2005.

*** In Argentina, only wage earners are considered for social security coverage, as self-employed are ignored. However, the resulting underestimation seems to be minor, since the participation of the self-employed in social security schemes is very low (Rofman and Oliveri, 2012).

SOURCE: Own elaboration based on CEPAL (2015) (Education, Healthcare), Rofman and Oliveri (2012) (Social security and pension coverage) and ILO (2015) (Health insurance coverage).

and the armed conflict between the Sandinistas and the US-backed Contras (1979-1990). Migration in the 1970s and 80s took on features of a massive escape, marked by a deepening political crisis and intensifying internal civil wars "that had repercussions throughout the region, but expressed most strongly in Nicaragua, El Salvador and Guatemala" (Morales and Castro, 2006: 18. Own translation). While the vast majority of these flows were directed to the United States (Maguid, 1999), Costa Rica, which managed to keep armed conflict at bay, received a large share of these political migrants, especially from Nicaraguan (Cortés, 2008).

With the advent of peace in the early 1990s[5], there was sizeable return migration of political refugees and people displaced by violence (Smith, 2006). However, as a result of the debt crisis of the 1980s and the economic transformations that followed, migration flows actually intensified significantly in the whole region (Acuña, 2010). Most of the migrants were young, unskilled workers in search of better job opportunities, primarily as irregular migrants to the US (Fix and Passel, 2001). At the same time, the Nicaragua-Costa Rica migration network flourished in this period. Generally characterized as labour migration (Sandoval, 2007; Moralees and Castro, 2006), it is motivated by the lack of labour opportunities in Nicaragua ("push" factor), and demand for labour in the Costa Rican agriculture and construction sector as well as domestic service ("pull" factors) (Voorend and Robles Rivera, 2011). For example, Nicaraguan migrant labour accounts for over 80% of the labour force in certain agricultural sectors such as sugar cane (*idem*).

In the 'new' economic model that took shape in the 90s (Rosa, 2008; Segovia, 2004; Robinson, 2003), the disjunctive between the more dynamic tertiary sectors and the more labour intensive primary sectors became larger (Sojo and Pérez Sáinz, 2002), and the latter was in dire need of cheap unskilled workers "only partially available in the country" (Morales and Castro, 2006: 231. Own translation). As such, migrant labour insertion is mainly in secondary labour markets, in which the pay is poor and where there is little social or labour protection (Voorend and Robles Rivera, 2011). Indeed, a significant share of the generally young Nicaraguan migrants, having enjoyed only limited access to formal education, finds jobs in the informal sector (*idem*). As a result, their access to Costa Rica's social services is not self-evident.

Indeed, there are very few and certainly no conclusive studies that discuss the incidence of Nicaraguan migrants in or their economic impact on social services in Costa Rica, or that discuss the ways in which migrants access social services and incorporate them in their survival strategies. The few available studies focus on the question of whether and to what extent Nicaraguans take advantage of overly generous social policies, and try to evaluate, some more elaborately than others, whether they are a 'burden' on Costa Rica's social services. However, data on social contributions and

usage of social services by nationality are limited, which makes the choice of indicator a sensitive issue. At the same time, studies capture only incomplete information on irregular or temporary migrants, since official national survey data overlook the majority of these populations. Also, most official data from national social welfare institutions does not allow for disaggregation by nationality, at best only by foreigners and nationals, lumping all migrants together.

In a descriptive, unpublished study based on data from the CCSS, Castillo (2003) uses an incidence analysis to show that migrants claimed between 4 and 6.3% of total CCSS services in 2002 —less than the share of the total foreign population in Costa Rica at the time (6.9%; INEC, 2002). However, Bonilla-Carrion (2007) comes to a different conclusion. In a study using data from the National Household Income and Expenditure (INEC, 2004) for the year 2004, he shows that Nicaraguan households in Costa Rica, in relative terms, made more use of social services than Costa Rican households, while simultaneously contributing more to social services. Hereby, the author challenges "arguments against migration and racist discourse" (158. Own translation). But, as he admits, the results are skewed by the fact that the surveys do not include undocumented migrant and temporary population.

Castillo (2011) shows how, between 1997 and 2011, the average costs of medical consultations and hospitalization for the foreign population increased by 473% and 1,052%, respectively. However, this study has some methodological shortcomings. Costs are calculated at current prices and when corrected for inflation the data suggests much smaller increases (of 50% and 200%, respectively). Most importantly, the author does not compare the cost of medical attention for nationals versus immigrants. Furthermore, the study does not take into account that immigrants also contribute to social security.

Other studies focus on the institutional and legal framework regulating migration (Fouratt, 2014a; Sandoval, 2012; Kron, 2011). Only López (2012) explicitly focuses on healthcare access, analyzing migrant incorporation in healthcare entering the country under a Bi-National Agreement (BNA) between Nicaragua and Costa Rica (see Chapter 2). López questions the healthcare system's universalism and argues that there is partial incorporation of immigrants, which reproduces vulnerabilities and dynamics of exclusion (López, 2012). Indeed, "regardless of whether temporary migrants have a legal right to reside and work in the country, they are all treated by officials in the health care system as if they are 'illegal' and thus suspicious patients" (López, 2012: 187). This echoes the argument that actual practices of social discrimination, rather than the level of formal rights, are the real problem of social integration (Faist, 1994).

Yet other studies contribute little substance to the debate, cross referencing and even literally copying parts of each other's analysis. An example is Carmona *et al.* (2007) which has little empirical evidence to offer on migration and social services

(healthcare, education and housing benefits) and goes no further than underlining previously mentioned recommendations concerning the need to find ways in which migrants can contribute more actively to the financial sustainability of the healthcare system. This would imply assuring formal labour market insertion and higher social security coverage, but they offer very little practical advice on how to overcome the constraining factors that lay the basis for this situation in the first place.

This ambiguity with regards to migrants' incorporation in social services is what constitutes fuel to the fire of anti-immigrant discourse in Costa Rica. Indeed, the Nicaraguan immigrant is socially constructed as a threat, which not only gives rise to discrimination, racism and xenophobia, but also forms an important element in the formation of public policies regarding immigrants (Feldman-Bianco *et al.*, 2011). The construction of boundaries around the distribution of welfare resources is relatively common in times of crisis (Faist, 1996, 1995). However, more often than not such reactions follow perceptions of immigration as a threat rather than a basis of credible data that shows a relationship between immigration and social policy crises (Feldman-Bianco *et al.*, 2011).

Notes

1 The use of 'illegal' for human beings is controversial, as no person is illegal for his or her personhood. However, throughout this document 'illegal' and 'illegality', in quotes, are used referring to a situation in which a migrant does not have a regularized legal status, or denizenship. This is done, following authors such as De Genova (2002) or Sharma (2003), to interrogate, rather than to accept the concept. Also, the concept of 'illegality' better reflects common narratives that 'irregularity'.

2 Europe's current migration crisis takes place at a moment when the welfare state has been weakened.

3 In the South, there have been several waves of migration throughout history, including migration in the 1970s and 80s associated to political repression. For Costa Rica, this means substantial inflows from other Central and Latin American countries, especially from Nicaragua.

4 Taking a simple average of per capita social spending in Nicaragua, El Salvador, Guatemala and Honduras.

5 In Nicaragua, the civil war ended with elections lost by the Sandinistas in February 1990, while the Chapultepec peace agreement of 1992 brought peace in El Salvador. The Guatemalan Peace Accords were signed December 1996.

CHAPTER 2

Migration Policy and Eligibility Criteria for Access to Costa Rica's Healthcare Services

2.1 Introduction

This chapter begins by reviewing the evolution of Costa Rica's contemporary migration policy. It situates recent migration policy reform in a historical context, showing that migration laws have been restrictive and based on security paradigms. This historical context is deemed important to understand not only the next chapter on the interplay between social and migration policy, but also to understand many of the arguments made throughout the entire document.

Second, while Appendix 1 provides a more detailed account of policy evolution in the healthcare sector, this chapter introduces the structure of this sector, and the role the CCSS plays in it. Finally, the chapter assesses the formal eligibility criteria for access to healthcare services in Costa Rica, and what this entails for migrants.

This chapter is based exclusively on documentary research of diverse sources, including published academic work, official institutional reports, articles on the websites of social policy institutions, legal documents like published laws, and internal communications of social policy institutions. These documents provided information on several topics. First, they supported an understanding of historical trajectories of public policy, and current critical analysis of laws and public policy regarding immigrant integration. Second, these sources allowed for a revision of the eligibility criteria for healthcare programs and an evaluation of the ease or difficulty with which migrants may access healthcare services. The chapter shows that health insurance and regular migratory status are key eligibility criteria for access to healthcare. That is, social rights are directly bound to health insurance.

2.2 Evolution of Migration Laws[1]

Despite migration scenarios changing rapidly in the early 1990s, with the onset of unprecedented migration flows from Nicaragua to Costa Rica (Sandoval, 2007), Costa Rica's lawmakers were not quick to adjust migration laws. Up until very recently, Costa Rican immigration was governed by a law which dated back to 1986. However, the legislative framework underwent two significant reforms in 2005 and 2009. Despite these reforms, a continuity in Costa Rica's immigration policy has been its almost exclusive focus on border control and other control mechanisms (migration categories, criminal records surveillances, and more recently fines) (López, 2012). This section discusses this continuity, providing a brief overview of the contemporary evolution of Costa Rica's migration laws and policies, which sets the stage for the institutional framework that allows or denies immigrants' access to social policy.

2.2.1 Before 1986

On June 7th, 1940, during the Administration of Rafael Ángel Calderón Guardia, a Law (No. 37) was enacted under the name "The Creation of the Migration and Foreigners Office". Finally installed in 1942, it provided a framework to orient and coordinate efforts related to migration, and unified entities with migration in their portfolio, such as the Ministries of Foreign Affairs, Governance and Police, and the Ministry of Public Security (Vargas, 1990). Specifically, and very much in line with restrictive immigration policy in the rest of Latin America, it created new entry restrictions for certain groups of foreign populations, based on racial categories like black people, or ethnic or national categories such as Chinese, Arab, Syrian, Turk, Armenian, and Gypsy (Bermúdez-Valverde, 2012).

However, it was not until 1952 that the National Migration Council was created as a first attempt to regulate migration. It was created as a body within the Ministry of Foreign Affairs, in order to encourage certain types of immigration and regulate and restrict others, while implementing control measures under the framework of international conventions. It was also meant as a research body on migration tendencies in Costa Rica.

This Council consisted of representatives of the Ministries of Labour and Social Security, Public Security, Agriculture, Foreign Affairs, Governance and the National Office of the Attorney (*Procuraría General*). In late 1957, an executive decree issued that the Council be moved to the Ministry of Public Security, because it had not met expectations of immigration control (DGME, 2011).

In early 1974, Law 5874 established that the Migration and Foreigners Office become the General Directorate of Migration and Foreigners (DGME, its Spanish acronym), a specialized organ of the Ministry of Ministry of Public Security on matters of immigration. It had several departments, all focused on migration control of the national territory, with land, sea, and air border control posts.

The government of Luis Alberto Monge Álvarez made significant adjustments to the administrative structure of the Executive Branch and approved a Law (No. 6812) in September 1982, establishing DGME as part of the Ministry of Governance, responsible for the execution of the country's migration policy. However, despite a series of decrees, internal communications, and resolutions regulating migratory functions, there was no real regulatory body with legal foundations that could govern the growing migration flows related to the political conflict in the Central American region in the 1980s. Therefore, the National Migration Council undertook the preparation of a draft law in line with the contemporary migration characteristics.

2.2.2 The 1986 Law: Regulating Migration

On the 4th of August 1986, the 1986 Law (No. 7033) was enacted and would be in place until August 2006. It placed the DGME under the Ministry of Police and Governance, and charged it with the execution of Costa Rican migration policy formulated by the Executive Branch. The Law served as an administrative regulatory framework establishing categories of entry and length of stay, and criteria for residency, work, and safe conduct permits.

Only once, in 1995, following a meeting among the Ministers of Labour of both countries, was the Law reformulated to create the *Tarjeta de Trabajo Estacional* (TTEs), a seasonal agricultural work permit for the sugar cane and coffee sectors (López, 2012; Borge, 2004). This was the first bilateral instrument to regulate migration flows, and to protect labour rights of foreigners as well as nationals (Borge, 2004). It served as a measure to monitor compliance with the constitutional and legal labour principles, and prevent unequal conditions of labour provision, avoiding unfair competition to the detriment of Costa Rican workers (Borge, 2004).

Although not an important reform of the legal framework in itself, the seasonal work permit was a significant feat in the sense that it was one of the first instruments designed to regularize and administer labour migration. In essence, it was aimed at Nicaraguan agricultural workers already in Costa Rica and administered access to a temporary regular migratory status for one year, although with the option to renew yearly. The Nicaraguan embassy committed to tracing undocumented migrants and

help them obtain the necessary documents to start the regularization process, from where the Costa Rican DGME took over to process the TTEs.

Unfortunately, this specific measure was short-lived and was no longer in place as of 1998 (Borge, 2004), mainly because the permit did not result in the expected regularization of migrants. It proved impossible to convert hundreds of thousands of migrants who had already settled permanently in the country into temporary migrants. Thus, the permit did not fit well with the type of immigration that took place at the time, and it was intended to "address a problem that was beyond the state's capacity" (Alvarenga Venutolo, 2000: 32).

In November 1998, following a regional Presidential summit on the humanitarian response to the social and economic disaster caused by Hurricane Mitch in Central America, a migratory amnesty was created under the administration of Rodríguez Echeverría. This amnesty, created to document and regularize Central Americans who had entered Costa Rica before November 1998 in irregular conditions, gave especially Nicaraguan migrants the possibility of a regular resident status for one year, with an optional yearly renewal (Mora Izaguirre, 2004). However, such measures were temporary and did not significantly alter the existing legal framework of 1986.

2.2.3 The 2005 Law: Securitization

On the 22nd of November 2005, during the Administration of Abel Pacheco de la Espriella, a new Migration Law (No. 8487) was enacted and came into force on the 12th of August 2006. This Law was the result of a reform process that started in 2001, as a reaction to the perceived problems migration created, especially from Nicaragua (Morales, 2008). It established control mechanisms that were "not well developed in the previous law, such as the surveillance of undocumented migrant populations, or the introduction of new regulation mechanisms to police criminal activities perpetrated by foreigners" (Lopez, 2012: 84).

The law was very punitive in nature, and notably the border police was given much authority, increasing its budget and improving border control infrastructure and enforcement. Immigration was positioned as an issue of national security, and the law criminalized the trafficking and aiding of undocumented migrants, allowed for the confiscation of identity documents and indefinite detentions by migration authorities.

Almost immediately after its public appearance, the law was met with heavy criticism from civil society (Fouratt, 2014a; López, 2012; Kron, 2011) that was especially concerned with the law's discriminatory and xenophobic stance towards migrants in general, and Nicaraguan migrants in particular (López, 2012; Jiménez, 2009).

Following this harsh reproach and a ruling of the Constitutional Court (2007-003653) that declared unconstitutional an article in the law prohibiting common law unions as grounds for family residency petitions, in a matter of months after the law's ratification, the new government commissioned the Ombudsperson's Office (*Defensoría de los Habitantes*) to critically assess the law. What was problematic in this law, according to the Ombudsperson, was its excessive emphasis on securitization issues such as the surveillance of the sex trade and activities related to drug trade and smuggling and the policing of migrants, while the human rights perspective was almost entirely overlooked (López, 2012). This revision would initiate a new round of reforms that culminated in the 2009 law, which is currently in place. Before it did, however, a binational agreement was signed with Nicaragua in a second attempt to regulate temporary labour flows.

2.2.4 The 2007 Binational Agreement

In December 2007 a bilateral agreement between Nicaragua and Costa Rica was signed. The Bi-National Agreement (BNA) is an agreement to legally recruit temporary migrants, and regularize Nicaraguan workers' incorporation in different sectors, especially agriculture (Bolaños, 2009; López, 2012). The impetus for this policy came from the center-right Social Christian Unity and the National Liberation governments of Abel Pacheco and Oscar Arias, respectively. These governments, in the years prior to the BNA's signing, actively promoted the Dominican Republic and Central America Free Trade Agreement (DR-CAFTA), which was expected to create at least 500,000 new jobs related to US exports (López, 2012). In this setting, the BNA would become an important mechanism to ensure the ordered and regular inflow of migrants to sectors of the economy in need of labour.

Under the BNA, employers can recruit temporary migrants both in Nicaragua and Costa Rica. Migrants already living in Costa Rica can only be recruited if their tourist visa has not expired, and the BNA excludes undocumented migrants. Workers residing in Nicaragua need an authorization from the Nicaraguan Department for Migration and the Nicaraguan Ministry of Labour (MITRAB), which provides a list of authorized migrants to the DGME. These temporary migrants are exempt from visa fee payments, but employers, who are responsible for ensuring that the migrants have passports or safe-conduct certificates and travel documents, do have to pay the DGME an entry fee per worker (López, 2012). Following the recruitment request from the employer, the Costa Rican Ministry of Labour and Social Security (MTSS) makes a suggestion to the DGME, following negotiations with employer associations

and analyses of labour market needs, based on which certain quotas are set. The DGME has the final word on the approval of the application.

Although still in place, the BNA is not considered a success and has been heavily criticized. Employers consider it a bureaucratic hassle and complain about the time and costs involved with legal recruitment, while the MTSS's institutional weakness to determine and negotiate realistic quotas and create an agile and quick recruitment process has become painfully obvious (Voorend and Robles Rivera, 2011). This has discouraged employers from taking part in the program (López, 2012; Voorend and Robles Rivera, 2011).

Furthermore, Bolaños (2009) lists a series of other critiques. Especially problematic is that the BNA is optional and does not constitute the only form of recruiting temporary migrants, as temporary work permits can also be filed when the migrant is in the country, although this also involves a complicated bureaucratic process. Second, as it only makes reference to temporary migrants, the BNA does nothing to regularize the legal status of the vast majority of permanently settled Nicaraguan migrants in Costa Rica. The BNA therefore does not necessarily counter the irregular recruitment of immigrant labour. Third, as it is aimed mainly at the agricultural, agro-industrial and construction sectors, it omits large populations in other labour markets, such as domestic labour and tourism. Fourth, while the BNA requires the signing of a labour contract, the content of such contracts is not specified, and in any case there is hardly any control on the actual labour conditions, or whether employers respect the minimum social and labour rights established by Costa Rica's legal framework. Finally, recruitment is limited to a single employer, making it impossible for migrants to switch between sectors, which Bolaños (2009) argues leaves them legally vulnerable to unjustified lay-offs when they "misbehave" in eyes of the employer. Similarly, it leaves them in a weak position to appeal substandard labour and living conditions.

As López (2012: 103) puts it, the BNA is "a dry normative procedure to regulate the admission of temporary migrants in which employers are central figures throughout its different phases, while the state plays a monitoring role —a comfortable position in a context of neoliberal policies". Following the economic and labour market effects of the financial crisis in 2008, especially hard felt in Costa Rica's construction and tourism sectors in 2009 and 2010 (Voorend and Robles Rivera, 2011), the MTSS was for some years reluctant to establish quotas to allow new migrant labour recruitment. With the economy slowly picking up, MTSS is once again analyzing labour demand (Ruiz Arce, 2014), especially for agricultural work where demand never quite stalled because of the difficulty of meeting labour demands with national workers (Voorend and Robles Rivera, 2011). For the 2013-2014 agricultural season, the MTSS processed 11.600 applications (Ruiz Arce, 2014).

2.2.5 The 2009 Law: Human Rights and Inclusion?

As part of the National Development Plan (2006-2010) of the Administration of Óscar Arias Sánchez, a proposal to reform the 2005 Migration Law was presented to the National Congress in 2007. The document was prepared by the Administration, but the following discussions constituted a more inclusive process than previous migration law reforms. Following the heavy criticism of the 2005 law, a genuine effort was made to incorporate the voices of civil society organizations like the National Network of Civil Organizations for Migrants, religious groups, academic institutions, think-tanks like the *Friedrich Ebert Stiftung*, as well as international organizations and regional institutions such as the Inter-American Institute of Human Rights. Public universities and international organizations like the International Organization for Migration (IOM) and the United Nations High Commissioner for Refugees (UNHCR) were also included (López, 2012). Central to this reform was the recognition of normative frameworks of international human rights[2]. In the words of the Ministry of National Planning and Economic Policy, the idea was to promote an "administrative model to organize migration laws according to a human rights perspective, that would make it possible for migrants to have access to Costa Rican welfare institutions and other public services offered by the State" (MIDEPLAN, 2007: 49).

Law 8764 was approved in August 2009, and came into effect in March 2010. Making multiple references to international human rights, the law, for the first time, commits the state to immigrants' social inclusion (Fouratt, 2014a; López, 2012) in Costa Rican society "based on principles of respect for human rights; cultural diversity; solidarity; and gender equity" (Law 8764, art. 3). In that respect, on paper it comprises a more integrated approach to migration policy, including various ministries (Housing, Social Security, Health and Labour) as well as migrant organizations in reporting and planning. Indeed, it orients immigration not only as an issue of security, but places much emphasis on its importance for development. The second article of the law states that "migration is a subject of public interest for the development of the country, its institutions, and its public safety" (Law 8764, art. 2).

Following this more "inclusive" discourse, the National Migration Council, traditionally in charge of migration policy design and implementation, the coordination of the Migration Police and the administration of customs and borders, changed in configuration and focus accordingly (López, 2012). On the one hand, where previously it was composed of the Ministries of Governance and Public Security, Planning, Labour and Foreign Affairs, it now includes not only the Ministries of Health and Education, the DGME, the CCSS and the Costa Rican Institute for Tourism but also two representatives of civil society organizations working on migration issues (López, 2012).

On the other hand, the focus of the Council, which had historically been exclusively migration control and security, now includes the challenge of integration and inclusion (López, 2012). Thus, in contrast with laws in most of the rest of the continent, the law and the institutional framework in charge of its implementation and adherence explicitly focus on social integration.

Despite this notable reorientation in the Council's focus, more critical analyses of the Law have raised concerns over how the "rhetoric of integration serves to legitimize [...] a number of troubling elements" (Fouratt, 2014a: 166) related to the persistent securitization of migration (Fouratt, 2014; Kron, 2011), such as increased authority and autonomy for the Migration Police and the possibility of repressive measures such as long detentions (Sandoval, 2012), and the high costs migrants are faced with when obtaining the necessary documentation for a prolonged regular stay in Costa Rica (see Chapter 3; Fouratt, 2014a; Voorend, 2014; Sandoval, 2012).

Indeed, somewhat contradictory to the human rights and integration language, the law granted more autonomy for the migration police, instituted new fees and fines ($100 for every month in Costa Rica as a migrant with an irregular status), and it changed a series of requisites for obtaining residence permits, incorporating for example a new requirement that foreigners married to Costa Ricans must wait for two years after marriage before applying for residency. Most importantly for this study, the law stipulates that affiliation to Costa Rica's social security system is required for starting the regularization process (Fouratt, 2014a; Voorend, 2013). As will be argued in Chapter three, this basically eliminates for migrants the possibility of family insurance (that indirect health insurance through a contributing family member) (Voorend, 2013). Another concern relates precisely to the State's new commitment to immigrants' social integration, criticizing the Law's ambiguous definition of integration as "integration in economic, scientific, social, labour, education, cultural, and sports processes" (General Migration Law 8764, art 7), and the lack of a public policy plan to operationalize this integration (Noy and Voorend, 2015; Voorend, 2014).

2.2.6 2010-Present: Delays and Transitorios

While it came into force in 2010, some of the Law's measures were delayed until 2011 and 2012. These delays were due to the lack of regulations guiding their implementation and enforcement, and concerns voiced and legal action taken by civil society. Concerning the controversial repressive measures, for example, a complaint by several civil society organizations before the Constitutional Court had to be resolved before these could be put into place (Constitutional Court, 2012). The complaint argued

that some articles of the Law were in direct conflict with the Constitution, as well as international conventions signed by Costa Rica. Specifically, it claimed the Law (8764, art. 18, par. 12) gives the DGME, through its Migration Police, excessive authority to apprehend temporarily (up to 24 hours) immigrants without need for evidence of infringement of any law. Also, the same article allows the police to retain the immigrant's passport or travel document, without any specified restrictions or time limits.

However, the Constitutional Court rejected any concerns over the high fines underlining the autonomy of the DGME to establish these matters and highlighted the need to sanction irregular stay in the country (Constitutional Court, 2012). Also, it rejected the complaint concerning preventive apprehension, although it did state that for this to happen, a justified resolution was needed that could be controlled by other institutional bodies. In all, the Constitutional Court argued the police could also retain passports, stating that this does not harm the basic constitutional rights of its citizens, and making multiple references to the duty of immigrants to regularize their migratory status (Constitutional Court, 2012).

Pending these resolutions, fines and deportations were put on hold until a series of temporary measures aimed specifically at the regularization of undocumented immigrants would end in November 2012. These *transitorios*, starting May 2012, were "temporary measures that provided a temporarily streamlined process for certain immigrant groups including, among others, migrants who arrived as children" (Fouratt, 2014a: 171). Specifically, they provided streamlined processes for the renewal of expired residency (after 2003) (*Transitorio 1*); Residency for parents of Costa Rican born minors (*Transitorio 2*); Statuses of humanitarian condition for migrants under 25-years old who entered as minors, and the disabled or elderly (*Transitorio 3*) and work permits for domestic workers and agricultural labourers (*Transitorio 4*).

In theory, these *transitorios* provided an opportunity for large numbers of migrants, especially those from Nicaragua, to gain legal status. In practice however, they were not well disseminated, and government agencies failed to coordinate their actions. For example, *Transitorio 4*, designed for agricultural workers and domestic workers, was circulated among construction workers not eligible for the program. Also, some government bodies collecting the fees involved with regularization did not know that they were lowered with the transitory measures and charged migrants the previously established fees (Fouratt, 2014a). In all, the 2009 Law has seen little change since, and it is seen by most in public institutions as a very acceptable administrative tool to control unwanted migration, while respecting international human rights frameworks. This view, however, has been contested by some, and will be critically questioned in the chapters to come.

2.3 The Healthcare Sector

In keeping with its generous social policies, Costa Rica has an extensive public healthcare system. This section provides a brief overview of the country's healthcare sector and its most important institution, the CCSS, prior to analyzing the accessibility of Costa Rica's current healthcare architecture for Nicaraguan immigrants.

2.3.1 The Caja

The *Caja Costarricense del Seguro Social* [Costa Rican Social Security Fund] (CCSS), colloquially known as *La Caja*, is the monopoly public institution in charge of social security in Costa Rica, and manages the provision and structure of public healthcare, the basic pillar of the national contributive pension system and the non-contributive pension regime[3]. It is home to Costa Rica's two principle social protection schemes: first, the country's main pension scheme, known as the Disability, Old-age and Death pension regime (*Invalidez, Vejez y Muerte - IVM*). This is the most important contributive pension scheme of the country. Administered by the CCSS, it was designed to cover all workers with the objective to provide economic benefits in case of disability, old age and death. It is mandatory for all employees in the public and private sector, including freelancers.

Its tri-partite financing scheme calculated over the employee's gross salary, consists of a 9.17% contribution rate, of which the employer contributes 5.08%, the worker 2.84% and the state 1.25%. Under the IVM pension scheme, a person is entitled to a retirement pension at the age of 65 years having made 300 contributions (although earlier retirement is possible with a higher number of contributions).

Second, the health insurance scheme, or officially the Sickness and Maternity Insurance (*Seguro de Enfermedad y Maternidad - SEM*) colloquially known as the *Seguro Social*, provides health insurance coverage for almost 90% of the population. There are several entry points to this insurance, which are largely contributive, but there are also non-contributive health insurance types. These are discussed in more detail in section 2.3.3. For salaried workers, the SEM is financed by contributions by the employer (9.25% of the salary), the worker (5.5%) and the state (1.0%). The self-employed and voluntarily insured contribute 9.25% of the reference income for their profession, while the state maintains its rate at 1.25% (Article 33 IVM Rules). These contributions give them a basic pension and access to health services. Also, the CCSS coordinates and executes healthcare prevention programs, such as vaccinations, and curative healthcare programs. It is in charge of all 29 public hospitals in the country, which are categorized as national, specialized, regional, and peripheral.

The CCSS is on paper an autonomous political body divided into six management departments: Administration, Medical, Finance, Infrastructure and Technology, Logistics, and Pensions. All institutional decisions are made by the Board of Directors, which is composed of three state representatives, three representatives of employers, and three of workers. However, the board is chaired by the executive president, appointed by the government. This means that the CCSS is mediated by the political project of the party in government, which determines the immediate horizon. It is also mediated by strong medical lobbies, especially of specialist doctors who have an important say in strategic and administrative procedures (Carrillo *et al.*, 2011).

Furthermore, the institution is quite large. In 2015, the CCSS had over 52,000 employees in 2015 and a budget of over 3.3 billion US dollars, 250 million of which is dedicated to the non-contributive pension system, and the remaining approximate of 3.05 billion to healthcare and health insurance (CCSS, 2015). To put this in perspective, this means the institution has a budget of approximately 685 US dollars per inhabitant of Costa Rica.

As a result, the CCSS represents a large bureaucratic and political system, in which many actors have vested interests. As such, the institution has come under scrutiny often, especially in times of financial hardship. Beginning 2016, for example, 13 high ranked officials were being investigated for fraudulent management of funds, and in June 2015, the Ombudsman had to warn the CCSS that its bureaucratic structure, especially the large amounts of paperwork and inefficient planning, in some cases violates Costa Ricans' right to healthcare (CRHoy, 2015). This complicated bureaucracy and paperwork is one of the hurdles with regards to migrants' access to health insurance and healthcare services.

2.3.2 A Brief History

In 1941, during the administration of Dr. Rafael Angel Calderon Guardia, the CCSS was created to administer an obligatory health insurance. Its aim was to protect workers in situations of disease, and later on, in 1947, to provide support in conditions of maternity, invalidity, old age, and death (Zamora Zamora, 2008; Garnier Rímolo, 2006). However, the health insurance's creation was met with heavy opposition from medical staff, who were worried about the implications for their private practice —from employers who argued that the economic situation caused by the war in Europe would not allow them to take on additional expenses and even the workers themselves who did not want to lower their wages to pay their part of the insurance (Jaramillo, 2004). On the first of November 1941, the *Ley Constitutiva de la Caja*

Costarricense de Seguro Social [Constitutive Law of the Costa Rican Social Security Fund-No. 17] was approved, establishing the legal framework for the institution's creation, and designating the CCSS as responsible for promoting and managing health insurance. Consequently, it was reformed in October 1943 to ensure the institution had the autonomy of self-government. Later, it was elevated to be included in the 1949 Constitution, making health insurance obligatory (Art. 73; Costa Rican Constitution).

Initially, the CCSS's insurance coverage was low because it was limited to formal, salaried, and almost exclusively urban workers, and excluded their family members. However, by the end of the 1940s, insurance coverage had grown to 23% of the economically active population and 10% of the total population (Garnier Rímolo, 2006). In the 1950s, healthcare services had reached urban areas and the Central Valley's coffee producing zones among low income workers first (Martínez Franzoni & Sánchez Ancochea, 2013). More importantly, this decade saw the extension of insurance to dependent family members and to rural areas. In 1956, a mandatory family insurance was introduced for the wives or companions of workers, their children under 12 years, and economically dependent parents. Between the late 1940s and 1960, the coverage of the salaried population grew from 23% to 38%. More importantly, because of this family insurance, health insurance coverage among the entire population grew from 8% to 46% in the same period (Miranda & Asis Beirute, 1989).

In May 1961, the Constitution was amended (Law N° 2738) determining that health insurance was to have universalist coverage in 10 years, which would drive the expansion of social protection in the following years. By the early 70s, health insurance had almost universalist coverage, and insured family members constituted 75% of the entire insured population, showing the importance of the family insurance for this universalist coverage (Jara Vargas, 2002).

The 1970s saw the creation of a national health system which aimed for national coverage of primary health care programs by the Ministry of Health through rural and community programs, and the universalization of medical attention for the entire population through the CCSS (Martínez Franzoni & Sánchez Ancochea, 2013). Also, in 1971, the CCSS's Constitutional Law (No. 4750) was amended to gradually extend social insurance coverage to all independent workers, and contribution ceilings of higher income employees were gradually eliminated to make the CCSS more progressive.

In September 1973, Law No. 5349 transferred to the CCSS all hospitals of other institutions, such as the Board of Social Protection, or the banana companies' medical establishments, and hospitals administered by the Social Protection Boards (*Juntas de Protección Social*) that operated under the supervision of the Ministry of Health. Subsequently, the Ministry of Health's focus was narrowed to preventive and primary healthcare, while the CCSS would run all curative services. In the 1970s, over three

quarters of hospitals and 81% of hospital beds were under the directive of the Ministry of Health. Fifteen years later, in 1985, the CCSS managed 85% of all hospitals, 95% of hospital beds, and 96% of hospital discharges (Miranda, 1994).

The 1980s and 1990s were marked by heavy pressure to reform the healthcare sector following Structural Adjustment Programs introduced after Costa Rica's debt crisis of 1981. This translated into a process of service integration between the CCSS and the Ministry of Health, with the aim to increase efficiency in the provision of healthcare services. Specifically, in 1993, this would result in the provision of all services related to health promotion, disease prevention, cure, and rehabilitation by the CCSS. The main focus of these reforms was to improve the service delivery model, and the organization and financing of Costa Rica's healthcare system. This resulted in a proposal of reorganization of the health system, which included several important measures. First, the available basket of healthcare services was rearranged by level of care: healthcare centres, clinics, and hospitals. Each of these healthcare providers was to offer standardized services to the public, focusing especially on increasing coverage on first level care. Second, the reform proposed a territorial allocation of healthcare services —that is, people access the different levels of health services depending on their domicile, except for the services only available at national hospitals (Martínez Franzoni and Mesa-Lago, 2003:45).

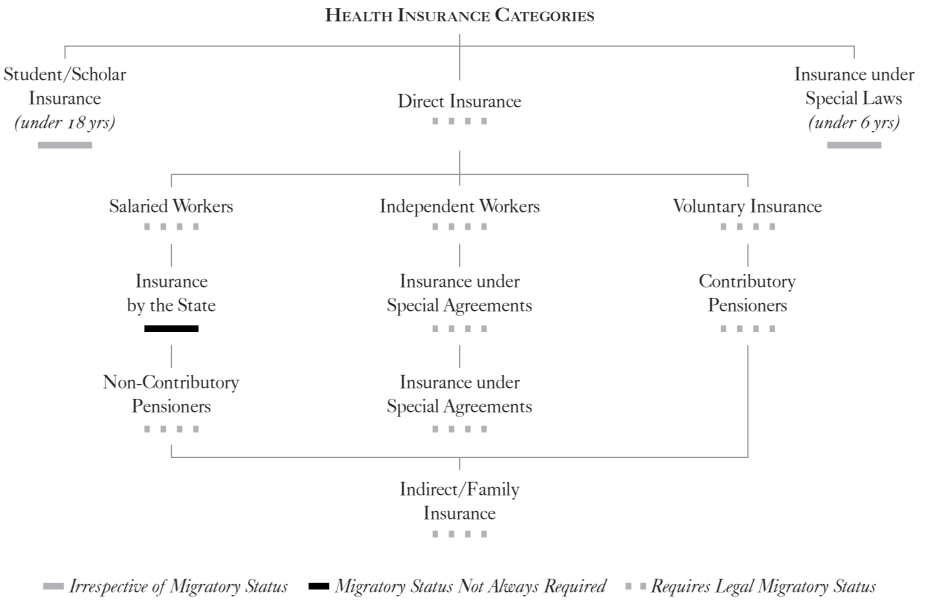
Third, to emulate market mechanisms within the institution, the financial, administrative, and service provision functions were separated, creating a system in which different departments with the health system function as actors that relate to each other fulfilling different roles or functions. Finally, while provision of healthcare services to the CCSS was opened up to private competition, the health sector reforms in this period did not change the CCSS's monopoly on social security and tripartite financing of healthcare service provision, thereby safeguarding the institutionally determined principles of universalism, solidarity, and equity (Martínez Franzoni and Mesa-Lago, 2003).

For the CCSS, the most important reform of the 2000s was the Worker Protection Law (*Ley de Protección al Trabajador*, No. 7983), which had important implications in terms of social security, making the CCSS responsible for raising employers' contributions related to labour capitalization funds and complementary pension funds. In terms of the provision of healthcare services, however, it did not propose radical change. Other than a series of small reforms regarding the Health Insurance Regulations which made minor changes to some terminology and definitions, there were no significant reforms during the first decade of the twenty-first century that altered the structure of healthcare service provision.

2.3.3 Migrants' Access to Health Insurance

Access to Costa Rica's healthcare system requires a *seguro social*, a health insurance exclusively issued by the CCSS. There are several different manners of acquiring this insurance, as presented in Figure 1, most of which require a legal migratory status. Largely speaking, there are four insurance categories. First, minors always receive medical attention, because they fall under the Student insurance, which covers any person between 6 and 18 years of age, irrespective of migratory status. Second, direct insurance is a personal insurance, mostly made up of a contributory insurance that covers salaried workers (in formal employment) and independent workers. Additionally, it covers people who apply for voluntary insurance, which offers the possibility of healthcare insurance without formal employment. There is also a direct insurance for pensioners, be it through the country's obligatory pay as you go pension scheme, the non-contributory pension scheme or a special pension regime. The direct insurance types also include a non-contributory type, Insurance by the State, which is a means-tested insurance for people who fall under the poverty line. This type does not necessarily depend on a regular migratory status, although in practice it is almost always required.

Figure 1. *Healthcare Insurance in Costa Rica's Social Security System*



Source: Own elaboration.

Third, there is an insurance category under special laws which provides universal and universalistic insurance coverage for minors under 6 years of age. Thus, children under 6 always have access to healthcare, irrespective of insurance or migratory status.

Finally, there is the possibility of indirect or family insurance, which can be extended to family members of any person with a direct insurance, irrespective of the specific category of insurance. However, that person must be a Costa Rican national or have a regular migratory status.

Once a person acquires an insurance, of any type, they have access to the public healthcare system. That is, while there are multiple entry points of insurance which might at first glance suggest a somewhat fragmented and stratified system, in fact once insured there are no differences in access to health services. The multiple entry points seem to have been created to extend coverage and accommodate for the different realities of different groups. For example, voluntary insurance is clearly aimed at informal sector workers who do not contribute through their payroll.

Also, the public system offers these services free of charge for the insured. That is, financing is completely based on indirect means, through general payroll taxes, and as long as a patient can present his or her insurance, that patient has full access to public health services and will not incur any extra costs at the time of need of medical attention, irrespective of his or her nationality.

Migrants and Health Insurance

Just like nationals, migrants need health insurance to access the CCSS's services. If and when they do obtain a *seguro*, in principle they should have free access to the same full range of services as nationals with insurance. Table 5 shows the types of health insurance in Costa Rica based on the 2011 Population Census, arguably the most reliable data available. The table compares Nicaraguan immigrants, understood as those people born in Nicaragua and residing in Costa Rica (representing 6.8% of the total population) with nationals (and nationalized immigrants). Note that the 'Insurance by the state" category includes the Student insurance and the Insurance under special laws, which means that minors from 0-18 years of age are included in this category. Also, the 'Other' category is made up of the remaining direct insurance types not mentioned separately, such as insurance under special agreements.

The data immediately show the difficulty of obtaining health insurance. First, although 65.2% of all Nicaraguans have some kind of insurance, the rest (34.8%) have no insurance. It is important to note that while this Census does capture irregular migrants, as it is based on documented residencies, at the same time, irregular migrants are expected to be underrepresented, given seasonal and informal migrant workers are

extremely difficult to capture with such instruments, and there is a general resistance among irregular migrants to participate in such surveys. For example, farm workers who live on-farm (under often questionable circumstances) would not be included. That is, it is likely that the percentage of 34.8% without access to social security is in fact a minimum estimate, and that in reality a larger share goes without coverage. Almost 13% of the Costa Rican population has no insurance, which in and of itself is not an insignificant share, and shows it is not fully universalistic.

Second, as Sandoval (2012) and Voorend (2014) have already noted, direct contributive insurance among Nicaraguan immigrants is higher than among Costa Rican nationals. If we compare salaried insured workers, and independent and voluntary insurances, 37% of Nicaraguans are covered, whereas these direct insurances only cover 31% of the Costa Rican population. It is notable, although not surprising, that independent and voluntary types of insurance are also more common among Nicaraguans than Costa Ricans. This in part reflects the fact that health insurance has been a requirement for regular migratory status since 2009, but also that migrants have higher labour participation rates (see Chapter 7).

Table 5. *Type of Health Insurance of Costa Rican Nationals and Nicaraguan Migrants, 2011.*

Type of Insurance	*Costa Rican Nationals (%) n = 3,915,813*	*Nicaraguan Immigrants (%) n = 287,766*
Salaried Workers	22.3	27.4
Independent Workers & Voluntary	8.7	9.6
Non-Contributory Pensioners	1.3	0.4
Contributory Pensioners	4.8	1.3
Family Insurance	41.4	22.8
Insurance by the State*	7.9	3.0
Other	0.7	0.6
No Insurance	12.9	34.8
Total	**100.0**	**100.0**

*This category includes the Insurance under special laws and the Student insurance. While technically these are different insurance modalities, in practice their bills are all paid by the Area of State Coverage, which is in charge of the Insurance by the state.

Source: INEC, X Censo Nacional de Población, Costa Rica 2011.

Third, it is family insurance that accounts for the lion's share of Costa Rica's social security's universalist coverage. It represents 41.4% of all insured people, and makes up almost half of the 87.1% of Costa Ricans with insurance. This family insurance is

much less common amongst Nicaraguan immigrants. Technically, the 2009 Migration Law and more specifically the interplay of social and migration policy has seriously restricted access to indirect insurance for immigrants, basically eliminating family insurance for adult migrants. The CCSS established in 2012 that a regular immigrant with a *seguro social*, can only insure a dependent adult immigrant if that person also has a regular migratory status, for which the 2009 Migration Law stipulates that a direct insurance for that person is required. This *de facto* eliminates family insurance for migrants, and means that it is likely to become less important for migrants as a form of insurance. Finally, the data reflect that other types of non-contributive insurance are much less accessible to immigrants than the national population.

The data in general reflect the fact that access to social security is not self-evident. Much of Chapter three discusses policy-induced restrictions to access, while Chapters six through eight discuss the difficulties migrants experience with regard to access to insurance in general, and healthcare services in particular.

Healthcare for the Uninsured

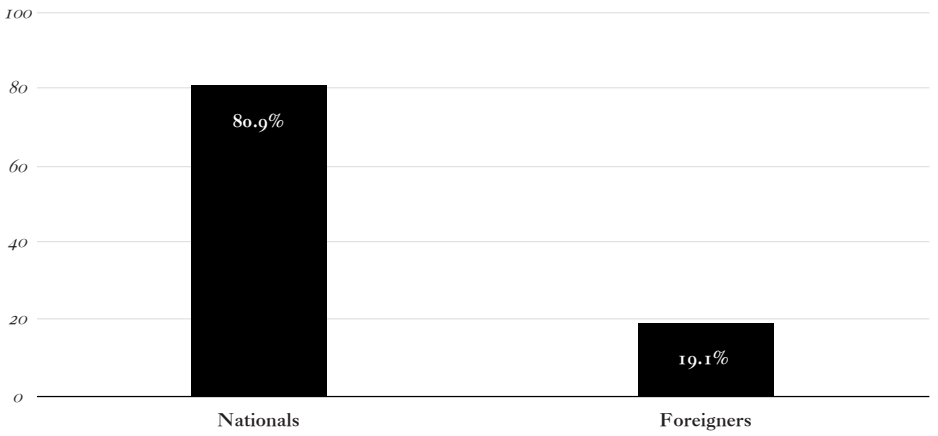
Indeed, the only two forms of insurance that do not require regular migratory status are Student Insurance, which covers all children in primary and secondary age enrolled in regular education, and Insurance by the State, an insurance for people who live below the poverty line. The latter insurance does require some form of identification, and is contingent on inability to pay for regular health insurance, in which case it is paid for by the State. Children of any nationality are always protected under the Childhood Code, and have unlimited access to healthcare services irrespective of migratory status.

While technically the Student Insurance, Insurance by the State (for people in working age, but in conditions of poverty), and the Insurance under Special Laws are different insurance modalities, the bills of the healthcare costs of those insured in these categories all go to the State Coverage department (*Cobertura del Estado*). This department also covers a residual category for people who receive attention from the CCSS (for example in emergency services), but who are in fact uninsured and cannot or do not pay the invoice presented to them. This is more of an administrative category that accounts for those cases where the CCSS has to cover the costs of medical attention already provided. Figure 2 shows the distribution of beneficiaries covered by this department (652,841 people at December 2012) disaggregated by nationals and foreigners.

A decomposition of the types of coverage of these 124,869 foreigners covered by the State Coverage Department is presented in Table 6. It should be noted that these data paint somewhat of a distorted image of what State coverage means. The table

includes those directly insured by the State, and their indirect beneficiaries. The data also include "uninsured covered by a law or special norm", which represent cases of patients that need and are provided with medical attention, but do not have the means to pay for these services. Notably, the data in the "Uninsured covered by a law or special norm" category does not necessarily apply to immigrants, but may also represent tourists (without insurance) that need medical attention. The same holds true for the "Minors insured by the State" category.

Figure 2. Beneficiaries of State Coverage of Healthcare Costs, December 2012.



Source: State Coverage Department, CCSS, 2013.

Third, and on a similar note, the data do not provide insights on the nationality of the foreigner, although given their share in the total immigrant population, it can safely be assumed that a large share corresponds to the Nicaraguan population. It is important, however, to mention these limitations of the data, because as will be argued in detail in other parts of this text, these kind of data are directly linked to the construction of perceptions of Costa Rica as a welfare magnet, and the (Nicaraguan) migrant population demanding healthcare services in a disproportionate way.

That being said, the data reveal an interesting story. First, 41.2% of all cases (dependent children of directly insured –4.9% -plus minors insured by the state- 36.3%) correspond to children who have true, universal, and free access to healthcare and education, as they fall under the protection of the Childhood Code. Second, another 31.9% of these foreigners are either directly insured (30.92%), or indirectly insured as spouses or companions (0.9%), meaning that the State has studied and approved their eligibility for existing insurance programs specifically designed for these means. Indeed, the data do not necessarily reflect their usage of healthcare services. The rest

(26.9%) corresponds to uninsured people who needed emergency medical services, but could not pay for them afterwards.

Table 6. *Foreigners with Healthcare Insurance Covered by the State, December 2012.*

Description	*Number of beneficiaries*	*%*
Directly Insured by the State (DIS)	38,605	30.92
Spouse/Companion of DIS	1,231	0.99
Dependent Children of DIS	6,136	4.91
Minors Insured by the State	45,308	36.28
Uninsured Covered by a Law or Special Norm	33,589	26.9
Total	**124,869**	**100.0**

Source: State Coverage Department, CCSS, 2013

Overall, state coverage for migrants refers mainly to general services for minors, and for people who require emergency healthcare services, which according to Costa Rica's legal framework and international treaties ratified by the state, cannot be denied to anybody. Access is truly universal for both, but as will be discussed in Chapter three, there have been attempts to limit access even to these services of the CCSS for undocumented and irregular immigrants. Other than emergency services, irregular adult migrants have no access to healthcare services, because they do not have health insurance. However, as will be argued in the chapters that follow, even regularized Nicaraguan migrants encounter a hostile environment to access healthcare provisions, in part because many do not know and are not informed about their rights to such provisions.

Notes

1 This chapter benefitted greatly from a thorough revision by Elise Hjalmarson, to whom I express my gratitude.

2 Notably, unlike in countries like Argentine and Chile where regional integration at least partly drove the recognition of human rights, Noy and Voorend (2015) argue that 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.

3 Costa Rica's pension system consists of 4 pillars, of which the first, a contributory general pension regime is managed by the CCSS, known as the *Régimen de Invalidez, Vejez y Muerte* (IVM, or the Disability, Old-Age, and Survivorship Regime). A second pillar, the Obligatory Complementary

Pension Regime (ROPC) is an obligatory individual capitalization scheme with the objective to provide supplementary pension benefits to the RIVM scheme. Third, the Private Complementary Pension Regime was created with the ROPC as a market mechanism for pension funds, allowing private operators to offer and administer workers' supplementary voluntary savings plans. Finally, the Non-Contributive Pension (RNC) scheme is meant to provide pension coverage to all those elderly in poverty and not covered by other pension regimes. While the money for the RNC comes from the Fund for Social Development and Family Allowances (FODESAF), it is managed by the CCSS.

CHAPTER 3

Shifting State Sovereignty. The Interplay between Social and Migration Policy in Costa Rica

3.1 Introduction[1]

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

Early globalist perspectives argued that states are increasingly unable to prevent certain types of migration. States then cede sovereignty to human rights agendas which prevail over national attempts of exclusion, eventually leading to the granting of social rights to immigrants. Such perspectives have since been challenged (see Chapter 1). Most importantly, states in the Global North have been inventive regarding migration control vis-à-vis international norms. Specifically, to counter or escape transnational normative constraints, they opt for more coordinated migration control at the international level (shifting up), decentralization of immigration policy to local levels (shifting down) and outsourcing of migration control functions to the private sector, by

disciplining behavior that is not in accordance with immigration policy (shifting out) (Guiraudon and Lahav, 2000).

However, are states in the South equally capable of circumventing international normative frameworks? This chapter critically assesses the Costa Rican state's reactions to migration in a context of economic slowdown, pressure on the provision of social services and a general perception of immigration as a threat to the availability of jobs and social services for Costa Rican nationals. Specifically, does the country limit newcomers' access to state resources, or is it bound by international human rights laws that ensure their social integration and equal rights?

In what follows, based on the Costa Rican experience, it is argued that states in the Global South may in discourse subscribe to human rights, but in practice find inventive ways to limit newcomers' social rights and circumvent international human rights norms. Specifically, it shows how the state shifts in mechanisms of migration control, transferring "responsibility to agencies [...] whose primary concern is not immigration enforcement, for example, hospitals" (Morris, 2002: 23). That is, certain groups of officially 'unwanted' immigrants are denied access to social services on the assumption that limits to social benefits may discourage migrants from moving to the country. Costa Rica's recent policy reactions to migration are testimony to the "multifaceted devolution of migration policy [which] shows the adaptiveness of agencies within the central state apparatus in charge of migration control" (Guiraudon and Lahav, 2000: 164).

Methodologically, this analysis is based on a critical review of the 2009 Migration Law, as well as a series of (internal) communications of the CCSS, issued in 2012. While such communications were sometimes internal, they are not classified and are shared with people outside the CCSS. For example, the communications used in this chapter were sent to several key employees of academic and civil society institutions, who in turn shared this information with me. These communications stipulate, clarify, change or enforce the institution's policy to its employees, and are important inputs to understand the internal and external functioning of the CCSS with respect to immigrants. Explicitly, taking a similar although slightly more pragmatic approach than Fouratt (2014a), this implies a discursive analysis and a close reading of these texts. This analysis focuses on how issues were framed and explicitly identifies the ramifications of policy on healthcare access of immigrant populations.

This critical analysis was consequently complemented with a series of 40 semi-structured interviews of anywhere between 30 minutes and 2 hours, with CCSS and DGME officials of different ranks (16 and 9, respectively), NGO officials (7), other state institutions such as the IMAS, FODESAF and the Ministry of Education (7) and the Vice-president of the Republic (See Appendix 2). A first round of 27 interviews

was conducted between March and May 2013. Having analyzed the information, a second round of 13 interviews was conducted between October 2014 and February 2015, to follow up on certain gaps in the information. Priority was given to the CCSS, as it is the country's most important healthcare and pension provider. Here, the focus was on high ranked officials who have decision making powers, medium ranked administrative officials, and lower ranked employees with little direct influence in decision making, but who directly influence the everyday provision of services. The interviews with the DGME followed a similar logic, focusing on the Director of Migration and high ranked officials of the Institutional Planning and Integration departments on the one hand, and service platform clerks on the other. Interviews with officials in other state institutions allowed confirmation of whether perceptions in the healthcare sector were also common in other sectors. The interviews with NGO staff and academics aimed to obtain a more critical view of migration reform and institutional practices enabling or hindering migrant access to healthcare.

The aim of the interviews was not to be representative of the respective institutions, or the particular level at which that interviewee operated, but rather to gather a range of different perspectives. The criteria for selection was a combination of identifying key informants on specific topics, by approaching strategically placed officials in important institutional departments (usually aiming for the highest ranked official) with snowballing, asking the interviewee for references on certain topics of interest that came up during interviews. This combination guarded against snowballing's danger of getting stuck in a fairly self-referential narrative loop, but at the same time ensured efficient coverage of key informants. The number of interviews was determined on the basis of repetition or saturation. After a while, across interviews and despite a variety of different perceptions, views and perspectives portrayed by interviewees, certain patterns and repetitions began to emerge. These repetitions provide a reasonable level of confidence that the data-gathering exercise covers a wide range of views. Once this level of confidence was reached, the interviews ceased.

The interviews served two specific purposes. First, they provided insights on the perceptions of policy makers and operational staff regarding immigration and its interplay with and impact on social policy. Specifically, the interviews discussed general characteristics of migration to and immigrants in Costa Rica, the idea of Costa Rica as a welfare magnet, the legitimacy of immigrants' welfare claims, and the current legal migratory and social policy framework in Costa Rica. Second, the interviews shed light on the policy processes and policy formation, and the dynamics of inter and intra-institutional communication and interaction which explain state reactions to the tense situation that has unfolded in Costa Rica with regard to the incorporation of migrants in welfare arrangements, and the recognition of their social rights.

Finally, all interviewees were asked to sign an informed consent form, and all gave permission to record the interviews. The interviewees were asked if they agreed to be quoted with their real names and functions, and in the consent it was stated that if they wished to remain anonymous, they could request anonymity. Only few did, in which cases they are quoted anonymously, and reference is made to their department only. However, for those that verbally agreed to be quoted, and did not state their objections when signing the consent form, it was deemed important to quote real names and functions. All interviewees represent public offices of public institutions, and are publicly accountable for their actions. Given their incidence in migrant integration, it was considered important that their opinions and perceptions were also made publicly available. The interviews were transcribed and processed using the processing software, MaxQDA.

3.2 Migration Reform and Healthcare Law Enforcement

Immigration in Costa Rica is "constructed as a problem primarily from the illegality that it is ascribed, [and] it is this illegality that structures the *vision of the State*" (Domenech, 2011:33. Italics in the original). As will be shown in this section, this vision forms the basis for Costa Rica's policy responses to migration flows and the crisis of its main healthcare institution, which despite the discursive recognition of international human rights, moves to limit access to social welfare benefits for migrants.

3.2.1 Migration Law Reform and Access to Healthcare

Besides certain protected groups, like children under 18 and pregnant women who have access to healthcare independent of insurance or migratory status, immigrants and nationals alike need health insurance to access non-emergency healthcare services offered by the CCSS. Until the 2009 Migration Law reform, immigrants were able to procure health insurance relatively easily as it was not conditional on migratory status. That is, 'legal' residents and 'illegals' alike had access to healthcare services, provided they either were insured by their employers, or had voluntary insurance. If immigrants (or nationals) did not have health insurance, they were only attended in case of emergency, and officially would be presented the bill afterwards, although, in practice, this seldom happened (Voorend, 2013). In reality, the state financed the services provided in these cases. Other general non-emergency healthcare services for the uninsured were available at market prices.

The Law establishes affiliation to the country's national social security system as a new requisite for obtaining regular migratory status. Specifically, "all processing

of migratory management must [...] ensure that each migratory procedure must contemplate, as one of its basic requirements, the [migrant's] possession of one of the social insurances the CCSS has to offer" (Law 8764, Article 7 - paragraph 7; own translation).

Sandoval (2012) argues that this is a harsh requirement, given the CCSS covers only six out of ten economically active persons. Indeed, the Law demands of migrants direct insurance, while only 31% of the Costa Ricans in 2011 was directly insured, either as a salaried worker (22.3%) or on own account (8.7%), a lower rate than amongst Nicaraguans (37%: 27.4% as salaried workers and 9.6% as independents) (INEC, 2011). Much of the CCSS's coverage for nationals comes from indirect (family) insurance, which covered 41.4% of nationals, but only 22.8% of Nicaraguans (INEC, 2011. See also Chapter 2, Table 5).

Furthermore, the cost of insurance represents a significant barrier to regularization. Without a formal employment contract, it is possible to pay for voluntary insurance of the CCSS, the costs of which represents a significant investment of up to 15% of a typically low-skilled informal Nicaraguan worker's salary (IIS *et al.*, 2012). For an unskilled person earning a minimum wage of about US $ 570 in 2015, this implies between US $ 50 and 85 per month. Many migrants do not earn minimum wage. In all, the costs implied with the requisites for a prolonged regularized stay in Costa Rica add up to between US $ 370 and US $ 800 (IIS *et al.*, 2012). Finally, the Law establishes significant economic fines for irregular stay, which are to be paid before starting regularization. As such, following Sandoval (2012) the new conditions do not stimulate the process of regularization, and the Law "produces the 'illegality' that it aims to eradicate [fostering] the absence of documentation" (7. Own translation).

3.2.2 Insurance and Regularization: Catch-22

The specific interplay of migration and social policy in Costa Rica creates an extra barrier for immigrants' social integration. This interplay becomes visible in a series of internal communications within the CCSS –of April 10, June 21 and 22, October 19 of 2012 and February 18 of 2013– in which a new requirement to obtain insurance is established and existing requirements to access the institution's health services are reinforced. Kathya Rodríguez Araica, Director of the DGME at the time of the interviews, confirmed that there was communication between her institution and the CCSS.

> With the previous director of the CCSS there was excellent communication, and with my technical staff and that of the CCSS. And from this the communications resulted, there were several of them (Kathya Rodríguez Araica, Director DGME, Interview, October 23, 2014).

In the first communication, of 10 April 2012, the CCSS informs its employees about "an addition to the guidelines for securing migrants as voluntarily insured and self-employed, in accordance with the Law No. 8764, the Immigration Law" (CCSS, 2012a: 1). When the CCSS's management, in an official letter that circulated in the institution dated 21 February 2012, established a series of guidelines for obtaining insurance, on March 9, the DGME issued a request to the CCSS which made it "necessary to implement an addition to the [previously] mentioned guidelines" (*Idem*).

Specifically, the new requisite states that "foreigners who apply for insurance for purposes of renewing their residence permit, must present their valid residence permit", or have to be able to show that all the paperwork for obtaining a regular migratory status are accepted and in process. In such cases the CCSS can issue a temporary insurance for up to two months (CCSS, 2012a).

In the internal memo of the CCSS (2012d: 2) of 19 October 2012, this requirement is confirmed, establishing a transitory measure "for insuring foreigners as voluntarily insured and independent self-employed: [...] in exceptional cases, for the person with an expired residence permit, the [CCSS] will proceed with the insurance, provided that the applicant presents official documentation issued by the DGME, or entities this institution authorizes, that the expired residence permit is in process of renewal".

This creates a Catch-22 situation from which the irregular immigrant can hardly escape (Voorend, 2013). The DGME demands insurance for a regular migratory status while the CCSS demands the latter as a requisite for insurance, thereby hindering the regularization process and access to healthcare services. Two rulings of the Constitutional Court, of end 2010 and end 2012, have questioned the sequencing of these mutual requisites, although not the requisites themselves. In a nutshell, following claims of immigrants about this Catch-22 situation, both rulings argued the CCSS's requisite of regular migratory status before issuing an insurance is not unconstitutional. However, they ruled that the DGME should issue a temporary permit that allows the immigrant to proceed with the affiliation to the CCSS's insurance. Once the insurance is issued, then, the person can return to the DGME to finalize the regularization process, which on paper should resolve the issue.

However, in practice this does not seem to be the case. A reading of the DGME's website in October 2015 of the requisites demanded for different migratory statuses showed that this solution is only possible for requests pertaining to permanent residence through a tie to a Costa Rican national. That said, the situation is confusing as another document on the same webpage with criteria for this same permanent residence category, does list affiliation to the CCSS insurance (DGME, 2014).

For all other types of regularization, of which temporary residence for migrant workers is arguably the most important for Nicaraguan immigrants, the DGME lists

the CCSS insurance requisite. Also, the fact that the first ruling, of October 2010, is followed by the second, exact same, claim (and ruling) in 2012, shows that the first does not set an apparent precedent for policy change. Furthermore, immigrant testimonies and interviews (Voorend, 2016) and more recent analyses of the reform suggest that in practice the Catch-22 situation is anything but resolved (Fouratt, 2014a).

Finally, another communication (CCSS, 2012c: 2) establishes that indirect insurance for migrants can only be extended to those family members that have regular migratory status. Specifically, it is stated that: "the granting of family benefits in the case direct insured applies when, in the case of foreigners, they have legal residence in the country". This means that for regular migrants who would want to insure irregular family members, the indirect insurance form is invalid, as all family members over 18 would first have to regularize their migratory status, which implies obtaining a direct and individual insurance.

In any case, the legally established requirement of insurance by the CCSS for regularization, following the request of the DGME, shows the explicit transfer of migration control responsibilities to the CCSS. The ensuing requisite of regular migratory status that the CCSS, following an official request of the DGME, establishes as mandatory for insurance, confirms the CCSS's unequivocal role in migration policy. Specifically, it represents a shift of migration control responsibilities inwards to other state institutions that traditionally had no role in migration policy.

3.3 CCSS: Law enforcement, Attacks on Universalism, and Confusion

Furthermore, after the 2011 financial crisis of the CCSS, the healthcare institution responded in three ways to limit access to its services by immigrants. Specifically, it began to enforce "aggressively" (Anonymous, Head of a CCSS Area, Interview, April 29, 2013) already existing laws, attempted at least two attacks on the principle of universalism for certain services, and in the process created a lot of confusion that left immigrants more vulnerable to discrimination, and the whims of the social clerk or doctor in determining who receives medical attention and who doesn't.

3.3.1 Law Enforcement

In another communication, the CCSS refers to the "duty of every official at the moment of attending the serving different users of healthcare services provided by the

institution, to VERIFY meticulously the insurance status of each and every one of them" (CCSS, 2012b: 3; capitals, bold and underline in original). CCSS officials were reminded that

> In case patients are attended in state of [...] emergency, one should proceed in compliance with the established procedures and protocols. After finalizing medical attention, the Medical Records Service clerk or the emergency services receptionist, depending on the case –in charge of the verification of the patients information and the pre-seal of the respective documentation–, will refer the patient to the Unit of Validation and Billing of Medical Services, where the corresponding bill will be prepared (CCSS, 2012b: 2).

For all other non-emergency healthcare services, the "UNINSURED patients [...] must pay the costs of the basic medical consult (in accordance with the effective tariff model), prior to the realization of the service" (CCSS, 2012b: 2; capitals in original).

This represents a stricter application of internal laws that already existed within the CCSS but until 2011 were only loosely applied, largely because the CCSS's financial situation allowed for more lenient management (Carrillo *et al.*, 2011). One Head of a CCSS Area explained that until 2011, the institution was not so concerned with this policy, but that now the CCSS has become more aggressive" (Anonymous, Head of a CCSS Area, Interview, April 29, 2013). She was immediately reprimanded by her superior, who was present in the interview, after which she changed her wording to "stricter". Indeed, irregularities "are better controlled because of the Migration Law" (Anonymous, Head of a Research Sub-Area, CCSS, Interview, April 29, 2013).

With this law enforcement, 'illegitimate' demand for healthcare services of irregular immigrants seems to be targeted. Emergency care is legally impossible to deny, but a price filter is put in place to limit certain minority groups' demand for these services. At the very least, it serves as a measure to deter people from approaching health clinics, unless it is a matter of life and death, because it would translate into a significant bill, although the CCSS was still in process of defining what happens if the person cannot pay the bill (Eduardo Flores, Head of State Coverage, CCSS, Interview, April 24, 2013).

3.3.2 (Failed) Attacks on Universalism and Confusion

There have been at least two recent attempts to limit migrants' access to healthcare. On October 31st 2012, the CCSS issued an internal directive (CCSS, 2012e) representing "the biggest attack on universalism of the last decades" (Sandoval, personal communication, March 4, 2013). In the directive, issued by the head of the State Coverage Department who, rather oddly, in an interview made the comparison that "pregnant women are better protected than the Central Bank" (Eduardo Flores, Head of State

Coverage, CCSS, Interview, April 24, 2013), the right to prenatal healthcare for pregnant undocumented foreign women was questioned. The directive had already passed the CCSS's Legal Department (CCSS, 2013a). Specifically, the communication stipulated that unidentified pregnant women, that is "those cases in which the woman does not carry any recognized identification document [...] or if these have expired, Article 74 of the Health Regulation is applied, which stated that an unidentified person may only access the services provided by the CCSS in case of [...] emergency" (CCSS 2012e: 1. Own translation). However, following a complaint from the academic sector and a pro-immigrant rights NGO called the Jesuit Service for Migrants (*Servicio Jesuita para los Migrantes)*, the National Ombudsman's office issued a complaint asking for an explanation from the CCSS. The CCSS then quickly withdrew the statement in a communication dated May 10, 2013, in which the previous directive was annulled (CCSS, 2013b).

The second attempt represented a lack of clarity concerning eligibility criteria. In the fall of 2014, the CCSS communicated updated requisites for a family insurance, which were interpreted by many to exclude the possibility for *any* migrant, regular or irregular, to make use of family insurance. That is, while a 'legal' migrant already could not insure an irregular adult dependent, now it was understood that he or she could not apply family insurance to regular migrant dependent family members, or even Costa Rican born spouses (Karina Fonseca, Director Jesuit Service for Migrants, Interview, March 5, 2013). This confusion grew to such a state that on the 14th of January 2015, following much criticism from pro-immigrant rights NGOs and beneficiaries, the CCSS had to clarify that the family insurance can be applied to ('legalized') family members of already regularized immigrants.

Whether this confusion was intentional or not, it does follow a more general trend within the CCSS, and it leaves a vacuum with regard to the clarity regarding which rules are to be applied. The first directive, for example, was never officially issued, but its mere existence has resulted in anecdotal evidence of service providers unlawfully denying undocumented migrant women prenatal attention. Similarly, the confusion concerning family insurance, meant in practice that several immigrants who legally complied with all the eligibility criteria were denied a family insurance. With such measures and practices, not only the principle of universalism is curbed, but also the everyday mechanisms of social policy that account for universalistic coverage.

3.4 Conclusions

In times of economic and political crises, it is a fairly common policy reaction to limit access to social welfare benefits (Morrisens, 2008; Baldwin-Edwards, 2002; Bommes and Geddes, 2000), especially in contexts of pressures to liberalize, deregulate and

diminish state presence (Ryner, 2000). This is exactly the scenario that Costa Rica is currently facing.

In response to the country's social security crisis, following voices of welfare chauvinism, it has been argued in this chapter that Costa Rica has taken measures to limit immigrant's access to health services. This contrasts strongly with the more inclusive human rights vocabulary that Costa Rica's recent migration reform boasts.

This shows that states in the South are equally capable, as states in the North, of withstanding the pressures of international normative frameworks surrounding human rights that advocate the extension of social rights to migrants based on personhood. The state continues to be of central importance for processes of social inclusion, and citizenship, or rather acquiring a regular migratory status, is a key determinant for access to national welfare benefits, even when human rights are formally acknowledged.

Indeed, despite recent migration policy reform in Costa Rica adopting more inclusive language, adherence to human rights principles, and acknowledgment of the need to integrate immigrants, the state circumvents these frameworks, by "shifting" migration control to institutions that are originally not charged with migration policy control, in this case the CCSS. Here, healthcare is used as a strategy for 'migration management', which ascribes to the idea that migration can effectively be administered to ensure it is ordered and predictable and therefore, more manageable (Domenech, 2011). Social policy and access to healthcare are then being used as a tool to limit migrant rights and migration more generally. Far from conceding state power and sovereignty as early 'globalists' would have it (Sharma, 2006; Jacobsen, 1996; Soysal, 1994), the Costa Rican state has found ways to sidestep international normative constraints, shifting the level at which control measures are elaborated and implemented.

Notes

1 This chapter corresponds largely to a paper published in *Transnational Social Review* under the same title (see Voorend, 2014).

CHAPTER 4

From the Frying Pan into the Fire. Perceptions of Costa Rica as a Welfare Magnet in the Context of a Social Security Crisis

4.1 Introduction[1]

In order to understand social processes in general, and those that drive the construction of boundaries around welfare arrangements limiting access to social services in particular, it is important to analyse the social construction of the immigrant as a threat by employees of state institutions in charge of the creation and execution of social policy. That is, policy reactions can be understood as outcomes of social and political processes in which "migrants are social agents operating in specific historical circumstances and situations" (Feldman-Bianco *et al.*, 2011: 17). Therefore, this chapter analyses state employees' perceptions of Nicaraguan migrants in Costa Rica, their right to healthcare, and their relationship with the financial sustainability of the CCSS. Specifically, the chapter covers the perception of Costa Rica as a welfare magnet for Nicaraguan migration. For this, one section looks at the centrality of social services as an attraction, and revises the anchor baby claim. Then, the difficulty of integrating Nicaraguan migrants is discussed. This difficulty is directly related to the kind of migration Costa Rica is perceived to attract, which is mostly poor and considered by some of inferior culture. Then, the specific relation between these migrants and Costa Rica's health services is analyzed, showing that regularization and insurance are considered as minimum necessary conditions for a legitimate claim to health services, but that the resistance many interviewees have with regards to Nicaraguan migration goes beyond these legal requirements, and is rooted in ideas of displacement of nationals in such services. Finally, perceptions are examined regarding the migration reform, discussed in Chapter three. In all, this chapter shows how many people who are directly and indirectly involved in migrant integration regard this integration as a challenge,

at a time that the main institution responsible for this integration is in financial crisis. As such, interviewees portray a general feeling of going from the frying pan into the fire: on top of having an institution that is struggling to maintain services for nationals, they have to deal with these (undeserving) Nicaraguan migrants.

Recognizing that the design and creation of policy passes through people who have perceptions of migrants and migration as a phenomenon, the implementation of social policy "depends on the person behind the service window" (Dobles *et al.*, 2013: 143. Own translation). It seems therefore crucial to understand the perceptions of actors in social policy institutions. Thus, to understand the processes behind legal and extra-legal forms of exclusion, it is important to analyse the social construction of the immigrant subject through the narratives of the people who design and create social policy as well as those that implement policy on a daily base.

These narratives are important as expressions of people's perceptions. Following Bourdieu (2000), depending on the position an agent occupies in a social space, he or she acquires a system of implicit and explicit dispositions, generating behavior "that can be objectively consistent with the aims of [that agent's] interests without having been specifically designed for this purpose" (Bourdieu, 2000: 119). That is, a person acts in what he calls a *habitus*, understood as a system of acquired practices, perceptions, and insights, based on that person's position.

Translated to the design or implementation of policy, narratives give insight to the position of the persons involved in such processes on migrant's rights, the legitimacy of their demand for social services and the way in which he or she understands immigration in relation to universal social services. Arguably, their practices are mediated through their perceptions. The window clerk who believes, like most Costa Ricans (González and Varela, 2003), that Nicaraguan immigration is at least partly accountable for the CCSS's demise, will probably treat a Nicaraguan and a Dutch immigrant differently. It is argued here that studying these perceptions, is important to understand the general context in which state reactions to migration take place and how processes of immigrants' exclusion from social services take shape.

This chapter approaches the narratives of these actors regarding their perceptions on the social rights of immigrants, and then discusses how these perceptions may translate into barriers to health service access for immigrants in Costa Rica. Methodologically, it is based on the interviews introduced in Chapter three with state employees. This particular chapter employs the 26 interviews with CCSS and DGME officials at different levels –high ranked officials, medium-level management and public health professionals, and finally operational window clerks.

4.2 From the Frying Pan into the Fire: Perceptions of Migration in the CCSS and DGME

4.2.1 Perceptions of Costa Rica as a Welfare Magnet

Before inquiring about the effects of Nicaraguan immigration in Costa Rica, the interviewees were asked why they believe Nicaraguans migrate, and more specifically, whether they think the social services available might motivate the choice for Costa Rica as a destination country. This chapter evaluates narratives regarding whether social policy as a pull factor that would be strong enough to explain migration to Costa Rica. In other words, do officials of the DGME and the CCSS consider the country a welfare magnet?

During the interviews, there were a variety of different responses, reflecting the institutions' diversity. However, it was possible to identify three narratives of which in at least two the welfare magnet idea is present. First, among the seven operational officials (including window clerks) of both institutions interviewed, there was a belief that social policy and specifically access to health services, are explanatory factors of migration from Nicaragua. Second, among the eleven higher ranked professional employees, including general practitioners, specialists and officials in higher managing functions, healthcare was considered a crucial factor in the decision to migrate to Costa Rica, but almost always as a complement to the search for paid work. Finally, the eight high ranked officials portrayed broader narratives focusing their attention on Costa Rica's long democratic trajectory, and the institutional strength that makes it a more prosperous and safe destination, in contrast with Nicaragua. The social policy regime forms part of that attractive package. Below, each of these positions is discussed.

Social Services as the Main Attraction

Most window clerks and operational staff of both the CCSS and DGME seemed to hold strong opinions with regard to the attractiveness of social services in Costa Rica. Many claimed that Nicaraguan migrants appreciate the Costa Rican health and education system, and that this explains to a large extent why they migrate to Costa Rica. A CCSS window clerk, who wished to remain anonymous, when asked whether he thought immigrants migrate because of the social services available, told us

> I think so, because the CCSS gives that kind of benefit to those populations. It covers 100% of the medical services, every time that person considers it necessary, they are given attention, and

> even with priority right, because they might have certain characteristics: a pregnancy, a delivery, a health check for their child (CCSS Window clerk, Interview, March 25, 2013).

A CCSS nurse seconds this relatively common view:

> I believe they do. This is maybe a bit redundant, but the Costa Rican Social Security, with all its weaknesses and all its strengths is a very attractive social security regardless of the fact that access to private services is on the rise (Gissele Roman, Nurse CCSS, Interview, March 19, 2013).

The migrant population is perceived to place much value on the benefits of the social services available in the country. One general practitioner told us that she believes Nicaraguan migrants value these benefits more than nationals because

> Ticos [Costa Ricans] don't know what they have. [...] The idea these immigrants or well, Nicaraguans, have is that in Costa Rica [health] insurance is free. Healthcare is expensive, and a Tico does not know it, but the foreigner does, because abroad they live in other conditions in their countries. So, of course, knowing that they can come here and the state will insure them, and will insure their children and they will see this as free of charge, well, for them it is a door to many other things (Marta Jara, General practitioner, Interview, March 25, 2013).

This contrast between Costa Rica and the "rest of Central America" is recurrent in the interviews. Where the latter creates adverse conditions that motivate people to leave, Costa Rica is generally perceived as an exception in the region:

> In Central America people see it that way, because if you analyse [the region] or how things are in Mexico, with the drugs, the *maras* [gangs], Costa Rica might have some of that but not to the extent as in other countries. Because, be it as it may, Costa Rica is like a Central American Switzerland, and while that may even not be true, compared to other countries we are much better off (*Ibid.*).

For some, this position of Costa Rica, as an exception and a welfare magnet, is a source of pride. A service clerk of a DGME platform explained that "many people come here for the system of the CCSS. Obviously, this makes us proud [...] and makes us look good" (Juan Carlos Siles, Service Platform DGME, Interview, May 10, 2013). This, however, does not necessarily mean that migrants' demands for the services of this system are perceived as legitimate, in part because "what happens is that we [...], from the institution, cannot cope and it delays us [...] in our work" (*Ibid.*).

Social Services as a Complement to Jobs

In the narratives of the higher ranked professional employees, such as doctors in managing functions, healthcare and education services play an important role in the decision to migrate to Costa Rica. However, the welfare magnet argument loses some of its centrality, as complementary explanatory factors were mentioned, such as wage gaps, the ease of finding work in the (informal) labour market, geographic proximity,

networks and family reunification. The labour component is more important, but most still believe that social services do come into play when deciding to migrate to Costa Rica. Principally, access to services for migrant children, especially education, is perceived as an additional attraction.

An emblematic narrative in this line comes from the Director of the *México* Hospital, one of the country's biggest hospitals. Dr. Douglas Montero considers the main reason people migrate is the lack of job opportunities in Nicaragua, and the higher probability of finding a paid job in Costa Rica, but at the same time believes that:

> ...it is not just job-related. Actually, Nicaraguans do not always earn well and are not always in good social conditions. Some work under bad labour conditions, in crowded settings and are badly paid. But they know that if they have an emergency they can access the services of the CCSS, they know that when their kids are born here they will have access to education, so they sacrifice some years of suffering to give themselves the chance to know the country [...]. It is a sort of long-term family strategy. These people have the opportunity to keep living in Nicaragua, they have their homes there, they have their conditions, but they prefer to come here for the Caja, for the better education that they receive here (Dr. Douglas Montero, Director of Hospital México, Interview, May 23, 2013).

A high ranked officer of the Integration Directorate of the DGME questions the idea that people only come for the social services available.

> I think that we cannot put it as exclusively that. It might be that it plays a role, for example here it is easier to enrol your child in school, and all that, and after a while they give him his breakfast and lunch at school [...] But it weighs strongly that these people come here to work [...]. At the end of the day, either you work or enjoy the benefits of the state (Cinthia Mora, Senior Advisor, DGME Integration Directorate, Interview, April 3, 2013).

One possible explanation for this more comprehensive view is that these officials have more access to information that goes beyond the red tape of window clerks, or the everyday operations of health staff. Higher ranked officials of the Integration Department, or Hospital Directors, seemed to be more knowledgeable on the subject of migrant integration as it is part of their portfolio. For example, Cinthia Mora questions the idea that health services are the main attraction:

> I wouldn't say that is the only [factor], right, because it would be a little risky to focus [the discussion] on "well, given we offer these services, so people come here". It would even be creating a myth that would imply that we would stop contributing [services to immigrants] because...right? [The myth is that] they come over and abuse the CCSS (Cinthia Mora, Senior Advisor, DGME Integration Directorate, Interview, April 3, 2013).

Thus, in these narratives the welfare magnet argument is still present in at least some of these narratives, but it is not considered the main driver.

> ...this population is poor and they stay in the country because it is better to be poor here than to be poor in their countries, because somehow they benefit more from other services. These people do

> not leave the country, they do not go [...] Just like it happened with construction when that sector fell because of the crisis, to what kind of jobs do these people go? They go to agriculture, but agriculture does not have the capacity to absorb them, but they stay. So they start developing informal jobs, a little thing here, a little thing there, but they stay in the country. Why? Because considering everything, and even with this situation in which they were left without a job, it is better to be here than in their country (Inspection Directorate, CCSS, April 29, 2013).

Social Services as Part of a Democratic Package

Finally, a narrative shared especially by the highest ranked officials of both institutions is the emphasis placed on the more abstract institutional conditions the country offers. The welfare magnet is not really present here, as social services form part of a larger package of democratic institutions, security and institutional development.

Possibly because these interviewees occupied posts in the institutions that were directly linked to the creation and management of policies, as well as the issuance and implementation of regulations and guidelines, their narratives reflect a more political discourse and abstract conceptualizations of migration and institutional logics.

For some of the highest ranked officials interviewed in the DGME and the CCSS, especially Nicaraguan migration is a result of the institutional solidity of Costa Rica as an 'exceptional' country in the Central American region. In this explanation, a stable and safe democracy is put forward as an important factor.

> When other people have asked me: what is the difference between Costa Rica and other countries of Central America? I have always told them that it is our democracy that has translated in the institutional development of the country [...] This institutional development [...] is a seal of guarantee for immigrants and the poor, knowing that they have access to good services of public health, education, housing (Eduardo Flores, Head of the State Coverage Department, April 24, 2013).

Similarly, a high ranking officer of the Inspection Directorate of the CCSS argued that:

> ...it is true that these people in their countries neither have the possibility of healthcare, nor education, nor clean drinking water, nor strong institutions. Because in the end, here, we are talking about institutionalism. Costa Rica is a country that has developed institutions, I mean, there are government bodies that are responsible for the provision of certain services. So in the end, this package becomes attractive. Maybe at a certain point there is the need for paid work, yes, but [...] you arrive and you get to know the country and you start to see what that country has to offer, and you start wanting what the country gives and you start demanding what the country gives (Inspection Directorate, CCSS, April 29, 2013).

Here, the country's social services are part of a larger "package deal" but, all in all, these narratives do not reflect the centrality of the welfare magnet argument, as social services by themselves lose explanatory power.

Anchor Babies

Legally, the *ius soli* principle dictates that any person born in Costa Rican territory is entitled to citizenship, regardless of the immigration status of the mother. Consequently, through the child, the parents can apply for regular migratory status. And while Goldade (2011) argues that women do not use this legal resource as often as elsewhere, it is a recurrent theme among healthcare providers (Spesny Dos Santos, 2015), as it was during the interviews for this research. Across ranks, interviewees provided anecdotes of immigrants having children or pregnant women crossing borders to give birth in Costa Rica as a strategy to gain access to Costa Rica's social services. The director of the *México* Hospital put it this way:

> Especially in the Northern region, [...] pregnant patients cross the border in the last month of their pregnancy just to have the child in Costa Rica, and to ensure that as Costa Ricans they will have all the [welfare] benefits, even if they just have the delivery and a week later are already back on the Nicaraguan side [...] They know that they can access the services of the CCSS, they know that when their kids are born here they will have access to education, because they have the big advantage of social security, of education, of safety that normally are more difficult to ensure in Nicaragua (Dr. Douglas Montero, Director of Hospital México, Interview, May 23, 2013).

Similarly, a CCSS window clerk mentioned the kind of anecdotal evidence that was quite common in the interviews.

> Yes, I can tell you about a pregnant lady that came to us in her thirty sixth week, and she told us the following: 'I came here exclusively to have the baby here'. She started prenatal control at thirty-six weeks, had the baby and left, because she said things here are very convenient, because they would not charge her for the hospital stay or for the controls (CCSS Window clerk, Interview, March 25, 2013).

4.2.2 The Problem of Integrating the Nicaraguan Migrant

In all interviews, and very much in line with the data on migration in Costa Rica (INEC, 2011), people perceive Nicaraguan migration as the most voluminous by far. While interviewees acknowledge that other populations also use their institutions' services, especially Colombians, US citizens and Canadians, these do not constitute the principle population demanding attention. Most interviewees, furthermore, recognized the large inflows in the 1990s and 2000s, while some have perceived a slowdown of immigrant stock growth:

> Look, Nicaraguan immigration, which is the biggest, was at some point growing exponentially and we were all worried that this could hurt not only the CCSS, but also the country, because there were people who used Costa Rican services but they were not contributing. This was extremely serious for the CCSS because they [the migrants] took away many resources, and were not giving

> anything. But this phenomenon -of large Nicaraguan [migration flows]- has stopped and instead we are seeing a phenomenon of decline, some are returning, and well, it kind of stabilized. Maybe, slowly the number of Nicaraguans is going down (Douglas Montero, Medical Director Hospital México, Interview, May 23 2013).

However, the problem that most interviewees perceive is the difficulty of integrating Nicaraguan migrants in Costa Rica society. In these narratives, the problems of integration are framed around issues that relate to the type of migration allowed to enter the country and important cultural differences between natives and migrants. Some of these narratives reflect discriminatory, and even xenophobic perceptions in which Nicaraguans are considered an inferior people.

Importing Poverty

The resistance to migration is not related to the migratory phenomenon per se, but its manifestation as Nicaraguan, low-skilled and informal migration. That is, Nicaraguan immigration has become anonymous with unskilled, 'illegal', and informal, and in combination with perceived cultural differences, these present inconveniences with regards to their integration. As Eduardo Flores put it, "there is consternation with regards to the increase of a certain type of migrant" (Eduardo Flores, Head of the State Coverage Department, April 24, 2013). A window clerk at the DGME explained his resistance to this type of migration:

> Well, for me, in general terms, [receiving] too many of these people is bad for the country. Why? Because we [Costa Rica] have fought hard for education, to bring down the number of illiterates and all that. Many of the people who come here don't know how to read and write, I mean, they come with their children and others, and they, [...] expect that the system, the education system, receives them. But when we then do a census to see how we are, the rate of people that can neither read nor write goes up (Window Clerk, Preferential Access, DGME, Interview, May 10, 2013).

Many of these migrant workers are perceived to "live in slums, where even we can't enter anymore, where the ambulance cannot enter because these are places taken by foreigners, and we are allowing it" (Window Clerk, Business Section, DGME, Interview, May 10, 2013). On top of that, the 2008 economic slowdown is perceived to have intensified the problem of having to "deal with" poor immigrant workers, because some of the productive sectors in which they are primarily inserted slowed down. Integration of the Nicaraguan immigrant population becomes harder because those "who do not find work, are left floating in the country because if economic activity slows down, they are left without work" (CCSS Inspection Director, personal communication, April 29, 2013).

As will be discussed below, the perceived profile of (poor) Nicaraguan immigrants, and the consequent difficulty to integrate them in Costa Rican society and

its social policy regime, are mentioned as factors that justify strict migration control. Adrián Jiménez, Deputy Chief of Institutional Planning of the DGME, made a direct reference to the need for migration control because of the poverty profiles of Nicaraguan immigrants:

> ...if we set limits this is because of the type of people that we want to have come over. Because, although it sounds really ugly, Costa Rica cannot be an importer of poverty, we have to deal with our own economic and social problems in the country. We cannot import a series of endogenous factors that come to make our own situation more critical (Adrián Jiménez, Deputy Chief of Institutional Planning, DGME, Interview, April 1, 2013).

Inferior Culture, Aggression and Criminality

Going a step further, although perceived to be related to the higher incidence of poverty among Nicaraguan immigrants, the difficulty of Nicaraguan migrant integration is explained as a function of cultural differences, something recent studies have also documented (Spesny Dos Santos, 2015; Goldade, 2009). Indeed, the narratives of almost all interviewees reflect perceptions of Costa Rica's cultural superiority. In a handful of the interviews, the narratives echoed ethnic-xenophobic, discriminatory perceptions unswervingly directed at Nicaraguan immigrants.

A common narrative shows how these cultural differences, for one, explain why immigrants do not have "their priorities straight", and spend their money on things that are perceived to be unnecessary. This in turn creates more resistance with regards to service provision to this population:

> Costa Ricans think of things like their home, of their own things, I don't know, for me [these are] important things. They [Nicaraguan immigrants] usually only have a super mobile phone, but they will tell you that they don't have money to eat. And they come here and so we have to see how we help them (Window Clerk, Preferential Access, DGME, Interview, May 10, 2013).

In these narratives, however, cultural differences are not only linked to the investment priorities of Nicaraguan immigrants, but also to aggression and criminality. For a high ranked official in DGME, for example:

> Much of the aggression towards women in Costa Rica comes from Nicaraguans. Here we have people of all sorts, but you will not see with such normality that a French man beats the crap out of his wife, or cuts off her arms, or an Englishman or a German, or an African or even an Argentinian or Brazilian. No, this matter is highly concentrated in Nicaraguan people. We have some Costa Rican cases, we have a Peruvian, an Ecuadorian, I mean, I am not trying to skew reality here, but if we analyse this matter in more depth, we realize that it is true that there are cultural patterns that strongly affect these kind of processes. It is not that I am a xenophobic, no! This is reality. [...] We are not saying that everybody who comes here is bad, [...] but bad people certainly come (Adrián Jiménez, Deputy Chief of Institutional Planning of the DGME, April 1, 2013).

These types of narratives reflect clear xenophobic perceptions towards Nicaraguan immigrants, distinguishing them from other nationalities. Eduardo Flores, Head of the State Coverage Department of the CCSS expressed concern for the "integration problem of second generation Nicaraguans", which the country has failed to successfully address because "it has no experience in its management... and yes, yes, this can become a serious socio-economic problem". Flores suspects that:

> The development of ambulant street sales, pirate taxis, the opening of informal diners and, who knows, but probably also the prostitution business and drug addiction is in hands of this [second] generation, because it is a group of people that has not completed basic education and does not feel good knowing their parents were not born here. They conserve a certain pride for being born here, but because of the conditions of poverty in which they grew up, they did not find the key to progress that Costa Ricans of that same generation have found (Eduardo Flores, Head of the State Coverage Department, April 24, 2013).

For some the presence of Nicaraguans in Costa Rica even puts at risk what is perceived to be a superior Costa Rican culture. Interestingly, in several of the harsher comments, the interviewees say they are not, or do not mean to be racist or xenophobic, but then go on to make comments which may be construed as such:

> What are the benefits [of immigration] at this moment? Shall I be honest with you? At this moment, I feel there are no benefits. I feel things [...] have changed. I don't want to sound [...] racist, but I simply feel we are losing our culture. Why? Because we are different, I mean, there is a difference between a migrant and us...We have a different way of being: for example, you don't see [Costa Ricans] with four children [...], now normally people have one or two kids. Compared to them, they have seven or nine, the Nicaraguans. Here, the majority of those people don't know how to read or write. So, what are the benefits for the country? [...] I think we are going too far, we will see what becomes of our country in twenty years. Costa Rica will be something else (Window Clerk, Business Section, DGME, Interview, May 10, 2013).

4.2.3 Legality for Legitimacy

Concerning access to social services, particularly healthcare, most interviewees recognize migrants' rights to such services as being equal to that of nationals. However, this recognition is conditional on regular migratory status and the fulfilment of their duties as denizens, most importantly obtaining a health insurance and keeping up with the contributions to the CCSS. That is, in the narratives, much emphasis is placed on the responsibilities migrants acquire when entering Costa Rica. Also, following Domenech (2011), the divisive line between the recognition and negation of social rights in the narratives of the interviewees runs through the 'legal-illegal' dichotomy. This, in turn, shapes the perceived legitimacy of the demand for health services of the Nicaraguan immigrant population.

The Good: More Regularizations, More Contributions

First of all, high ranking officials of the Integration Directorate of the DGME recognized, on the one hand, that there are now more migrants in regular migratory conditions, and on the other, some pointed out correctly that migrants are not to blame for the financial hardship faced by the CCSS. Julio Aragón, the Director of Integration of the DGME, affirmed that based on "the reports of the CCSS [that we asked them to present] it is not true that the country's healthcare system collapsed because of abuse by foreigners (Julio Aragón, Director of Integration, DGME, Interview, April 1, 2013). Interestingly, and in contrast with most narratives in which regularity and health insurance are consistently conceptualized as individual responsibilities, this particular interviewee highlighted employers' failure to live up to their responsibilities:

> The myth that existed that the foreigners were stealing from the CCSS and that because of that the CCSS is bankrupt. Well that is not true! What was shown is that there is much evasion by employers, much evasion to insure these people and that the employers are keeping that money, right? (Julio Aragón, Director of Integration, DGME, Interview, April 1, 2013).

Similarly, a window clerk of the CCSS felt that nowadays:

> There is a little bit more of this migratory status formalization, with that of the residence permit, because it has been solicited from our institution to give people an insurance if they have their residence permit (Juan Pablo Barrantes, Window Clerk CCSS, Interview, March 25).

The Bad: Too Many 'Illegals'

However, even in the narratives of those interviewees who perceived increased rates of regularity, there is a general perception that many immigrants are 'illegal', and that this 'illegality' is problematic with regards to the provision of social services. The same window clerk of the CCSS, went on to say that "here, there are many [migrants] that are, I think, illegal. But many enter the country with, what is it called, with a passport stamped as a tourist, and they overstay the time limit" (Juan Pablo Barrantes, Window Clerk CCSS, Interview, March 25).

Indeed, Julio Aragón affirmed that this is in large part due to the fact that "here, there are productive sectors that prefer to contract immigrants in an illegal manner, and here we come back to the topic of illegality" (Julio Aragón, Director of Integration, DGME, Interview, April 1, 2013). The Director of the *México* Hospital shared his view on this problem of legal migratory status for the institution he directs.

> The migrant population that comes to the Hospital, often does so without adequate documentation. So what we do, once their situation is attended to, is implement the invoice, but these invoices end up being uncollectible, because they usually don't have the financial capacity to pay

> them. That way, immigrants see the hospital as an advantageous opportunity, because they know that we have to attend to any patient, immigrant or no, if they have an emergency and we have to solve the problem. [...] Afterwards, those who can pay, pay, those who can't, don't. The majority of migrants does not pay. The problem is that they don't have access to monitoring services for pathologies or consequent complications, nor medical consult, if they don't have a *seguro social* (Dr. Douglas Montero, Director *México* Hospital, CCSS, Interview, May 23, 2013).

'Illegality' is considered problematic, because it implies not contributing to social security. Adrián Jiménez argues that "we cannot deny anybody attention, but if he or she is not insured, here you go: here is your bill. I mean, we have to be solidary, but not stupid, because otherwise the CCSS breaks" (Adrián Jiménez, Deputy Chief of Institutional Planning of the DGME, April 1, 2013). On an important side note, this quote shows notable paradoxes in the narratives of high ranked officials of the DGME. The idea that the CCSS might "break" if they are "stupid", stands in direct contrast with studies by the DGME (2011) that have shown that the immigrant does not represent a substantial burden for the social security system, a fact that was mentioned in the same interviews.

The Ugly: from Illegality to Illegitimacy

For all interviewees, the right to social services is conditional on the duty to contribute. That is, demand for social services is considered legitimate if, and only if, the migrant is 'legal', and 'contributes' to the country in general, and to health insurance in particular. It is notable that the human rights discourse, on which the actual migration law and policy is said to be inspired (Kron, 2011; López, 2012), hardly features in the narratives of the interviewees, and certainly does not have the same centrality that a legal migratory status has for the perceived legitimacy of social service demand.

A window clerk of the DGME business platform actually expressed his discomfort with Costa Rica's recognition of human rights:

> The error [Costa Rica has committed] is that we sign everything that they put before us with regard to human rights, without thinking about what it will bring for us, if it will imply some benefit for us, or if it will not benefit us (Window Clerk, Business Section, DGME, Interview, May 10, 2013).

Instead of recognizing rights based on personhood, legitimacy derives from contribution. In many narratives, it is mentioned that migrants cannot 'simply' arrive and start claiming without complying with their duties:

> Now, if you come and tell me: 'I want this, and you have to give it to me now', well ok, hold on a moment, you knew that you can't just come and ask, that you also have obligations. What happened with that? Ay no, ah ok! So you first comply with this and then I give you that. We have to make people see that it is not just a matter of rights, but also a matter of duties so that the institutions can better accommodate (Adrián Jiménez, Deputy Chief of Institutional Planning of the DGME, April 1, 2013).

In the CCSS, the narratives coincide. In the Direction of Inspection, the highest ranking official considered that a migrant is welcome if…

> …while he is here, he does things well, and then with all the pleasure. [They have to comply] because he might go, but another will come and will find a system that receives him, right. That is the big struggle, and this whole topic, I think has changed us as Costa Rican society, because they had this idea that the CCSS…they had the perception that the CCSS means gratuity (Inspection Direction, CCSS, April 29, 2013).

The problem with the idea that the legitimacy of demands for healthcare is conditional on 'legality' and 'contribution', is that 'legality' is not a mere product of a regular migratory status, nor is 'contribution' necessarily a function of actual payroll or voluntary contributions. Both these conditions are very much based on perceptions. In fact, 'illegality' is often assumed and ascribed to the migrant subject. For example, López (2012: iv) found that "policy makers and service providers tend to ignore the differences between these migrant workers and other migratory categories (such as 'illegal' migrants) and consequently deny benefits to all migrants regardless of their status".

The even Uglier: Ransacking Social Security

The perceived illegitimate demand for social services from Nicaraguan immigrants, specifically healthcare, for many of the interviewees jeopardizes the financial sustainability of social policy institutions, even despite studies (often by these same institutions) showing this not to be true. This concern is especially, although not exclusively, present in the narratives of officials working at the operative level. For example, Giselle Román, a CCSS nurse, is very conscious of the fact that certain healthcare services cannot be denied. In this case for pregnant women:

> If she meets the requirements; that means one cannot deny her [medical attention]. So yes, it does affect the institution, and yes, we do see that the funds of the CCSS are being affected (Giselle Román, CCSS nurse, Interview, March 19, 2013).

And given it is the "state that pays all this, so, […] in that part it does affect us economically" (Window clerk, CCSS, Interview, March 25, 2013). Thus, in such narratives, the demand for healthcare services for migrants has an extremely negative connotation, as it directly "affects, let's say the economic situation, the situation of the CCSS, […] because they [migrants] are given benefits that are covered by the state. […] They are covered by laws, special laws. So that definitely affects us. Who do we charge for those costs?" (*Ibid.*).

This erroneous, but persistent idea that Nicaraguan migrants do not contribute to social services is considered a complicated problem that has its roots in cultural

differences. A high ranking official from the Inspection Direction of the CCSS explained that the problem was directly related to a "lack of culture, where the other comes to ransack the *seguro* instead of contributing" (Inspection Direction, CCSS, Interview, April 29, 2013):

> Yes, maybe those of us who work in this department, we do know [the importance of contribution]. And then in the country people say that the CCSS is part of our idiosyncrasy. I mean, I believe that this country cannot imagine itself without a system of social security. Why? Because we were born with the system, born in the system. That is why we have these struggles with undocumented immigrants. The fight is for us to contribute together. I mean, yes, they deserve a humane treatment because they confront many [negative] situations, but let us then receive a population that wants to sustain the *seguro social*, and not ransack the *seguro social*. [...] Because that is what it means to be solidary. We are solidary receiving immigrants, but the immigrants must be solidary with the country where they arrive (Inspection Direction, CCSS, Interview, April 29, 2013).

The Hideous: Overflowing Social Services

Finally, another important concern present in the narratives does not directly relate to the financial sustainability of social policy institutions, but rather to a fear that immigrants saturate the system. For example, a clerk at one of DGME's preferential counters, beyond a concern for the impact of migration on the financial state of the CCSS, considers that by offering "so many services to immigrants, we are taking them away from Costa Ricans" (Juan Carlos Siles, Service Platform DGME, Interview, May 10, 2013).

This concern, principally expressed by officials at the operative level, transcends the 'legal-illegal' divide that forms the basis for the financial concerns previously discussed. That is, in this case the narrative reflects a perception that foreigners, irrespective of their migratory status or whether they contribute or not to the social security system, are affecting the available services for Costa Ricans. That is, they oversaturate the system of healthcare services.

> It turns out we are overcrowded with foreigners, and I go back to the same, [it takes from] people that need attention in our social security system (Giselle Román, CCSS nurse, Interview, March 19, 2013).

Interestingly, in these narratives, interviewees referred to foreigners, or migrants in general, and did not place the same emphasis on the 'illegal' migrant person. The questioning of social rights, in this case, goes beyond the issue of 'legality' or 'contributing' to insurance, but is directly linked to a desired exclusivity of welfare benefits for nationals, and presents a serious controversy over the legitimacy of demand for healthcare services by migrants in general, for their representation as 'foreigners', 'others' or 'outsiders'.

4.2.4 Migration Reform and Enforcement as a Solution

Costa Rican migration policy has an explicit, and almost exclusive focus on the regularization of migration flows (Voorend, 2014). The director of the DGME at the time, Kathya Rodríguez, succinctly summarized this, saying "my mandate is to regularize, regularize, regularize" (Kathya Rodríguez Araica, Director DGME, Interview, October 23, 2014). Her expressed interest displays the idea of migration management, that is, efficient regulation and management of migration flows in such a way as to maximize potential benefits and minimize possible negative consequences (Venturas, 2015).

> I want to know who they are, where they are, what they are doing and document them. I don't mean to frighten them, but I do want them to become regularized, and to those people who do not comply with these rules, explain 'you do not comply so you cannot stay'. That is, to put them in order and create this culture of documentation (Kathya Rodríguez Araica, Director DGME, Interview, October 23, 2014).

Regularization, on the one hand, is seen as a remedy to the issue of 'illegality', at least formally, and on the other, helps ward off illegitimate demand for social services, reserving the latter for 'contributors' at least, although few interviewees would prefer reserving them for Costa Rican nationals. Interviewees were asked about their perceptions of the changes to migration legislation, and the law enforcement processes within the CCSS.

All narratives reflected approval of the legal instrument that constitutes Law no. 8764. It is first and foremost a tool to manage migration and integration:

> ...we insist that it be an ordered and safe migration because the undocumented migrant himself is very vulnerable. So, [...] it is important to get legal documents, to make them visible in the country, because I'll tell you this: before, even a migrant that did not have a regularized legal status could buy a house, get a driver's license, could get insured, could go to school, could do everything. They told me they could even open a bank account, but that is part of the disorder (Kathia Rodríguez Araica, Director, DGME, Interview. October 23, 2014).

Furthermore, it is generally perceived as an instrument that allows for the transmission of the Costa Rican culture of 'solidarity' to migrant populations, creating awareness with regards to their duties, especially regarding the importance of regularization and contributing to social security.

A high ranking official of the Inspection Directorate argued that it was necessary to change the law, given:

> They [Nicaraguan migrants] lack the sensitivity with regard to the solidarity principle, and the importance of contributing. I mean, they don't have that culture, so we have to build that culture. I don't think it is just a matter of criticizing the immigrant, who comes and does not want to contribute, or the immigrant criticizing nationals about being discriminated. No, this is a deeper issue about how we construct a culture of contribution (Inspection Direction, CCSS, Interview, April 29, 2013).

The process of creating awareness is recurrent in narratives. The Law is understood as a process of creating such awareness with regards to the importance of regularization, contribution, and the priorities set by migrant families. This way, the Law manages:

> ...influence priorities. To give a random example, instead of that satellite dish of Claro or Direct TV, the priority should have been regularizing one of the members of that household, and after that the satellite (Julio Aragón, Director of Integration, DGME, Interview, April 1, 2013).

The high costs involved with regularization, which has been one of the main critiques of the academic and NGO sector, are not mentioned. The Law is positively perceived as a means to order unwanted and irregular migratory flows, and neither DGME nor CCSS officials consider this to constitute a form of discrimination.

> More and more [...] the country has to be ordered, so we have to place things in their real context. I am not treating anybody bad if I am asking for documents. For God's sake, it's only logical that you need documents (Inspection Direction, CCSS, Interview, April 29, 2013).

Stricter CCSS law enforcement (see Chapter 3) means that, besides regular migratory status as a requisite for social insurance, patients without insurance are not treated, unless their case is considered an emergency, in which case the person is charged for services. This trend within the CCSS is not questioned by officials of the institution, regardless of rank. Furthermore, it is generally considered positive, on the grounds of the discussed reciprocity that is expected from the migrant, but also based on a technical argument. It was often mentioned that regularization and healthcare insurance made it safer to treat people, as it allows healthcare professionals to construct a health record which decreased his or her risk of health complications.

The Law and CCSS's policy are not questioned for the difficulties they have created for migrants' access, or the bureaucratic processes and the costs involved with regularization (Voorend, 2013; Sandoval, 2012; IIS *et al.*, 2011). Quite to the contrary, some interviewees mentioned the benefits these policies have for the migrant population receiving social services. For Dr. Ana Patricia Salas, of Service Control in the CCSS, the measures directly benefit the immigrants:

> Well, I believe that it helps them instead, it helps them [...] because with documents and all, they can access [social] services at any moment. Before you saw a part of this population going to Emergency at night when there was no longer control of the validation of rights. Now, them being regular, their *seguro* gives regular access, and besides the contribution is also giving them a future pension. Maybe before there were people who were here for 10 or 15 years and had never been insured (Ana Patricia Salas, Service Control, CCSS, Interview, April 22, 2013).

4.3 Conclusions

The interviews show a large variety of opinions. However, among interviewees of operational staff, the idea that Costa Rica is a welfare magnet is recurrent. For higher ranked management officials, social services also play an important role in the choice of destination, but always combined with the availability of jobs. Among the highest ranked officials, the welfare magnet argument was expressed in more abstract conceptualizations of what makes Costa Rica attractive, such as democracy and institutional development. Interviews, however, also reflect a perception of cultural superiority, arguing that there is a lack of 'culture' of solidarity and contribution among migrants, which is perceived as a threat to welfare arrangements. The Nicaraguan migrant, then, is more often than not seen as a "necessary evil" (Dobles *et al.*, 2013: 187), irregular and unable or unwilling to contribute to welfare arrangements. In such circumstances, their claim to social services is considered not to be legitimate. The financial hardship the public healthcare system is facing, to which references by interviewees were common, seems to harden positions on migrant incorporation into welfare arrangements. That is, there seems to be a general perception that dealing with migrants' demands at this moment implies that the CCSS is going from the frying pan into the fire.

It is not possible to establish a direct relationship between such perceptions and policy processes. However, it is similarly difficult to argue that the former does not, in any way, influence the latter (Feldman-Bianco *et al.*, 2011). In this chapter, the narratives of a selected sample of officials of two of the most important institutions concerned directly with immigrant integration were analyzed. It is important to analyse these narratives because they reflect perceptions that may influence policy processes, both as its design and formation, as well as its everyday execution (Dobles *et al.*, 2013).

Indeed, many of the narratives of high ranked officials align with recent policy reactions limiting access to social services for immigrants. And many of the narratives of officials at the operational level align with anecdotal and documented evidence of discriminatory practices that limit Nicaraguan immigrants' access to social services at the window level.

Concerning policy reactions, for example, the narratives explain much of Costa Rica's more restrictive migration policy, both directly reflecting the persistent perception that being 'legal' is conditional on 'contribution' to the country's social policy regime, and being 'illegal' is synonymous to not 'contributing'. Law enforcements have principally aimed at fortifying the contribution logic of the solidary social security system, something all interviewees perceived a necessary condition for legitimate healthcare demand.

Migration policy has crystallized almost exclusively as a policy of regularization, and all interviewees saw this as a necessary condition for migrants' social integration.

However, as will be discussed at length in the following chapters, it is by no means a sufficient condition. Indeed, practices of discrimination that create situations in which regular and contributing migrants are denied access to social services (Voorend, 2014; Dobles *et al.*, 2013; López, 2011) happen at the window level, during the everyday interaction between migrants and service providers. It does not seem far-fetched to assume that the often hard narratives of operational officials, reflecting xenophobic views regarding Nicaraguan migrants, lie at the basis for such practices of everyday exclusion.

Effectively, social policy is executed at the "window" on the ground floor of the social policy institutions. However, on the tenth floor, where social policy is created, the same tension exists between an acquired commitment to provide services, recognition of human rights and historically entrenched principles of solidarity and universalism, and the desire to deny access to patients and beneficiaries who are perceived 'not to deserve' these services.

Notes

1 This chapter is partly based on an article written in Spanish with Karla Venegas Bermúdez, entitled: "Tras de cuernos, palos. Percepciones sobre Costa Rica como imán de bienestar en la crisis del seguro social", published in the *Revista de Ciencias Sociales* of the University of Costa Rica (Voorend and Venegas, 2014). Since then, it has been substantially reworked.

CHAPTER 5

Social Services as a Magnet? The Incidence of Nicaraguan Migrants in Health Services

5.1 Introduction[1]

Many Costa Ricans believe that Nicaraguan migrants are a threat to social security (Gonzalez and Varela, 2003), that they are more likely to use public social services, less likely to contribute to these services (Bonilla-Carrión, 2007), and finally, that they saturate social services, especially public healthcare (Dobles *et al.*, 2013; Bonilla-Carrión, 2007). This chapter, based on data publicly available from social policy institutions, or made available upon request, analyzes whether Nicaraguan migrants are overrepresented in healthcare services, by using incidence analysis to critically assess the extent to which Nicaraguan immigrants make use of Costa Rica's public health services as compared to their share in the population. That is, does the Nicaraguan migrant population disproportionately use social services? The chapter employs incidence analysis, and not benefit incidence analysis. Where the former assesses the share of Nicaraguans in the total attended population for healthcare services, the latter is a method used to compute the distribution of public expenditure between different populations. Unfortunately, the available data do not allow for this more complex method.

Notwithstanding its shortcomings, the incidence analysis does permit an interrogation of the perception that migrants disproportionately depend on social services. In fact, for some services, it shows actual use is almost non-existent. This strongly contrasts with common perceptions of many of the officials of social policy institutions interviewed, whose narratives were discussed in the previous chapter.

5.2 Perceived Estimates of Nicaraguan Incidence

Indeed, when asked to estimate the percentage of migrants attended as a share of all service seekers, operational and professional officials of the CCSS offered answer of between 30 and 60%.

> ...of every ten people, maybe three. It varies. Sometimes there is more, sometimes a bit less. For example, in medical appointments there are times that I prepare four files, and four are foreigners, so that is 100%. Sometimes one in four, or one in five depending on the type of attention. It varies, but yes, it is quite a lot (Juan Pablo Barrantes, Window Clerk CCSS, Interview, March 25).

Another CCSS window clerk estimated this share to be 50%, while Giselle Román, a CCSS nurse, suggested 60% (Giselle Román, CCSS nurse, Interview, March 19, 2013). Similarly, Marta Jara, general practitioner, told us:

> Nicaraguan immigrants [represent] maybe over 50%. There are days that the consult is basically Nicaraguan, although you might not believe it [...] It is a bit of a mix most of the time, but I can tell you much of medical appointments is Nicaraguan (Marta Jara, General practitioner, Interview, March 25, 2013).

The following section presents a more critical and nuanced analysis of migrant incidence in social services.

5.3 Migrant Incidence in Healthcare

This section, based on data provided by the CCSS, constitutes an analysis of migrant incidence in the healthcare sector, to compare with the perceptions previously discussed. Before examining incidence rates in healthcare services, an important reminder is in order. Some of the data obtained from the CCSS does not allow for a disaggregation of insured and non-insured patients. Thus, there is a risk that (Nicaraguan) migrants are assumed to be "uninsured" patients. However, data from the national census show that 65.2% of the Nicaraguan born population residing in Costa Rica has some type of health insurance, as has been discussed in Chapter two.

5.3.1 Insurance: the Myth of Non-Contributing Migrants

For 2006, the CCSS reports more disaggregated data that allow for comparisons by nationality[2]. In Table 7, the number of emergency procedures in 2006 is shown by nationality (country of birth of the patient) and insurance type[3]. In contrast, "standard" annual data on medical services in the CCSS are only recorded by a national-foreigner

divide. The data on emergency services is particularly useful because if high immigrant presence is to be noted somewhere, it is in healthcare data on emergency care. Emergency services can hardly be avoided because of the emergency situation, for one, and medical attention is always granted because of the inalienable right to emergency attention, even if the invoice would be presented afterwards (and possibly not paid). As Spesny Dos Santos (2015: 5) argues, although in practice access to emergency healthcare is often difficult for undocumented migrants, they do access such services, sometimes displaying strategies "relegated to the margin of morality" (lying about their personal characteristics, health complaints, legality etc.). In contrast, non-emergency attention, such as general hospital admissions, may not be available to uninsured foreigners, because on the one hand, the CCSS can refuse services, and on the other, it is questionable whether uninsured migrants would seek medical attention for non-emergency conditions. That is, if anywhere, in emergency services we would expect high immigrant presence.

Table 7. *Number of Emergency Attentions Provided by the CCSS, by Country of Birth and Insurance Type, 2006.*

		Country of Birth			
Type of Insurance	***Total***	*Costa Rica*	*Nicaragua*	*Colombia*	*U.S.*
Total	**4,463,776**	**4,186,995**	**228,074**	**10,704**	**4,531**
Sickness and Maternity	64.2	64.6	59.8	63.5	33.8
Direct Insurance	27.7	27.1	37.0	44.4	15.0
Family Insurance	36.5	37.5	22.8	19.1	18.8
IVM (Disability, Old Age)	5.7	5.9	1.8	2.7	2.5
State Coverage	15.3	15.6	11.0	9.0	8.8
Pensioned by State	1.2	1.3	0.2	-	1.3
State Insurance	10.5	10.6	9.6	9.0	6.3
RNC	3.6	3.8	1.2	-	1.3
Special Laws	3.3	3.3	2.9	1.6	5.0
Uninsured	11.5	10.6	24.6	23.3	50.0

Source: CCSS, Health Statistics Area, 2006.

The data show that three out of four Nicaraguans who seek emergency medical care from the CCSS are covered by some form of insurance. Nearly 60% of these people have direct (37%) or family insurance (22.8%). Notably, in line with the 2011 national census data, Nicaraguans (and Colombians for that matter) have a higher rate of direct

insurance than nationals, and lower rates of family insurance. Also remarkable is the fact that U.S. citizens are most likely to be uninsured (50%). Unlike Nicaraguans, these patients do not present any significant controversy with regard to demand for healthcare services.

In any case, the rate of insured Nicaraguan patients is higher than what many health professionals believe. Unfortunately, the available data do not allow for cross tabulations in which incidence in services can be referenced with insurance. Therefore, in what follows, it is important to keep in mind that a majority of Nicaraguans, and Nicaraguans seeking (emergency) medical services in particular, actually have health insurance, and thus contribute to such services.

However, as was argued in Chapter four, the welfare magnet argument is not only articulated along the lines of the 'contributing' and insured, but is also reflected in the idea that foreigners compete with Costa Ricans for the limited available social services available. Indeed, based on ethnographic work, Spesny Dos Santos (2015: 7) argues that "the 'national' versus 'migrant' categories are distinguishable and often more determinant than 'insured' versus 'uninsured'". Thus, here the distinction between insured and uninsured is less important, and foreigners' incidence can simply be compared to nationals'.

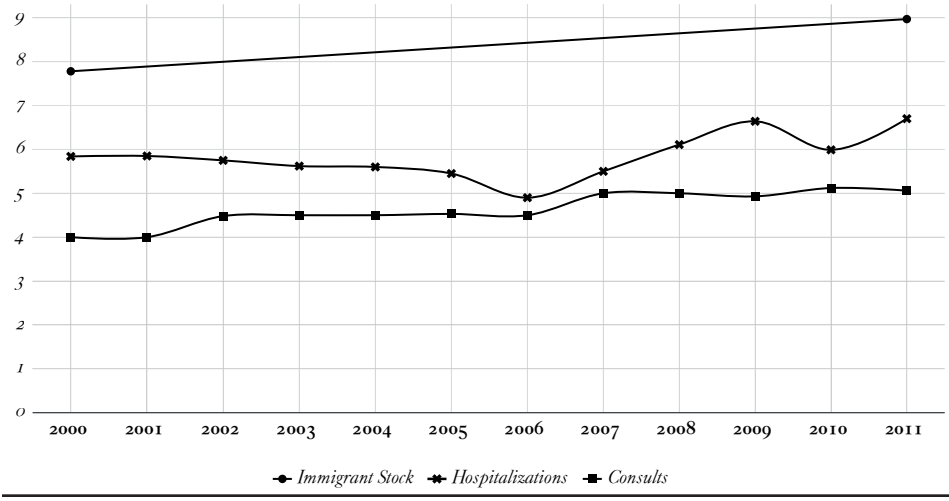
5.3.2 Medical Consultations and Hospitalization

Data from Castillo (2003-2011) and the Directorate of Health Services Projection of the Health Statistics Area of the CCSS (2011) provide information on the number of consultations and hospitalization for the period 2001-2011 (Figure 3). However, these data do not allow for a disaggregation by nationality, only by the national-foreigner divide. In Graph 1 they are contrasted with the migrant 'stock', that is, the migrant population as a share of the total population, in 2000 and 2011, years in which a national population census was conducted.

Between 2000 and 2011, the population census registers an increase in migrant stock from 296,461 to 385,899, representing an increase from 7.78% to 8.97%[4]. During this same period, the incidence of the migrant population in consultations and hospitalizations is not, at any point in time, higher than 7%. For both consultations (+/- 5%) and hospitalizations (+/- 6%), the share of immigrants using these services is lower than their share in the population. Put differently, rather than an overrepresentation of immigrant population in health services, the data suggest the opposite[5]. That is, this simple comparison suggests that Nicaraguan migrants are not over or misusing healthcare services.

It is important to note that this incidence refers to the number of cases treated, and does not say much about the share of resources spent on migrants versus nationals. Unfortunately, such data is currently unavailable, but there is 2006 data on the incidence disaggregated by the specific type of medical services.

Figure 3. *Percentage of Migrant Consultations and Hospitalizations Compared to Migrant Stock, 2001-2011.*



Source: Castillo (2011) and Health Statistics Area, CCSS (2011).

5.3.3 Emergency Medical Attention

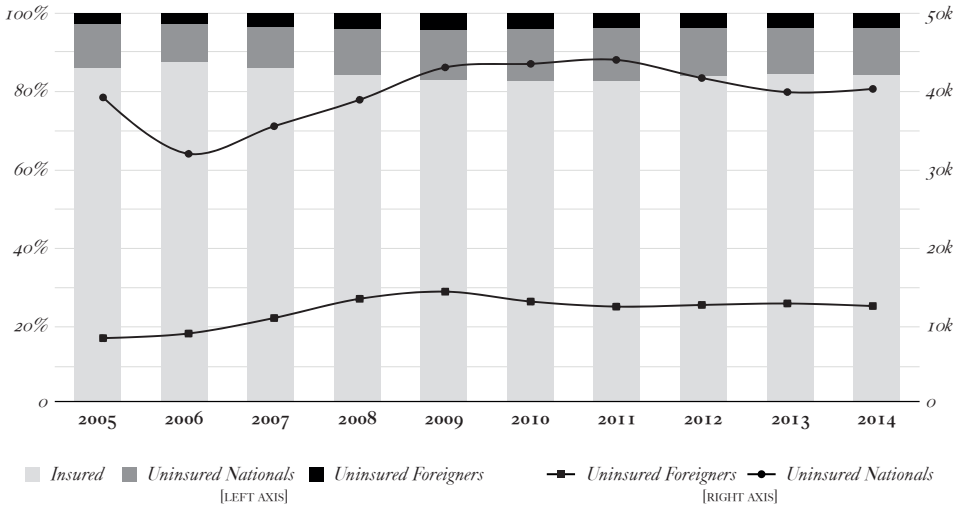
Data for 2006 allows for more detailed analyses, showing incidence in specific health services by nationality. These data are somewhat outdated, and one could argue that the attitudes towards migration analyzed in the previous chapter are for much more recent years, rendering the comparison incomparable to present day perceptions.

However, based on the evolution of the number of hospitalizations between 2005 and 2014 in Figure 4, for which the CCSS reports only the number of uninsured cases by national vs. foreigner, it is arguably safe to assume that the general trends have not changed considerably[6]. Table 8 shows the incidence in emergency attentions for a selection of specific diagnoses, by nationality. The criterion for selection was a minimum of 50,000 cases that year, so these represent the most common emergency treatments by the CCSS.

Several things catch the eye. First, the incidence of Nicaraguans in the total amount of emergency services (5.11%), is almost proportional to their share in the total

population (5.5%) in 2006 (INEC, 2006). Second, for most diagnoses and especially for those that have a large weight in the total number of emergencies, like infectious and parasite diseases or respiratory system diagnoses, the incidence of the Nicaraguan population is significantly lower (3.9% and 3.3%, respectively) than their share in the population.

Figure 4. *Evolution of Number of Hospitalizations, by Insurance and National vs. Foreigner, 2005-2014.*



Source: Own elaboration based on CCSS, Health Statistics Area, 2005-2014.

Third, while it is still nowhere near the 50% incidence some officials perceived, there is a higher incidence for emergency services related to pregnancy and birth. Given its central importance in welfare magnet arguments, especially around the idea of 'anchor babies', this will be discussed in further detail below.

Fourth, there are some other diagnoses with slightly higher immigrant incidence, like medical attention with pathology, services related to the genitourinary and the digestive system. However, an internal medicine specialist of the CCSS, Dr. Yúrika Dorado Arias, explained that there are three interrelated explanations for the Nicaraguans' higher incidence in these diagnostics. First, most of these conditions are quite common, like those related to the genitourinary system –infections of the urinary tract, vaginal bleedings and menstrual disorders–, but are usually not treated as emergency, because people with regular check-ups, or who seek medical attention with the first symptoms are treated through non-emergency health services.

Table 8. *Emergency Attention by Country of Birth for selected Diagnoses, 2006.*

Diagnoses	*Total*	*Incidence (%) by Country of Birth*		*Compared to 5.5% Incidence in Total Pop.*
		Costa Rica	*Nicaragua*	
Total	**4,463,776**	**93.8**	**5.11**	**-**
Pregnancy, Birth	130,320	86.9	11.3	+
Care without Pathology	187,239	90.5	7.9	+
Genitourinary System	241,780	91.1	7.8	+
Digestive System	272,193	93.0	6.2	+
Mental Disorders	83,877	93.0	5.4	-
Skin Diseases	141,816	93.3	5.2	-
Circulatory System	134,398	93.9	4.6	-
Nervous System	86,427	94.3	4.4	-
Ear Diseases	173,419	95.2	4.1	-
Infections and Parasites	372,042	95.0	3.9	-
Endocrine, Nutrition and Metabolism	53,691	94.5	3.9	-
Respiratory System	1,180,410	96.0	3.3	-

Source: Own elaboration with data from CCSS, Health Statistics Area, 2006.

However, the higher rate of uninsured Nicaraguans (see Chapter 2, Table 5) translates to problems of access to non-emergency services. For example, without insurance they will not have access to *Equipos Básicos de Atención Integral en Salud* (EBAIS–Basic Units of Comprehensive Health Care) or other healthcare centers. Even with a health insurance, these services are not always accessible to or sought out by Nicaraguans. For example, focus group data confirm that many Nicaraguans feel they do not have a right to such services (see Chapter 6). This way, conditions that are easily treated in their early stages, often develop into more complicated issues that require emergency treatment (Dr. Yúrika Dorado Arias, Specialist CCSS, Interview, May 9, 2014).

Second, this lack of control and follow up care is not only a problem in Costa Rica, but also in Nicaragua. There, the public healthcare system not only fails to cover the entire population, but also offers inferior quality services (Martínez Franzoni and Voorend, 2012a and b. See also Chapter 6). Insufficient medical controls in their country of birth explains the higher incidence in some of these diagnoses among Nicaraguan immigrants in Costa Rica. For example, vaginal bleedings are often secondary effects of tumors in the uterine fibroids, diagnoses that are more common among Nicaraguan women over 35 years old because of lack of medical control in

previous years (Dr. Yúrika Dorado Arias, Specialist CCSS, Interview, May 9, 2014). Again, relatively simple treatments can thus become more serious complications.

Third, many of the most common emergency diagnoses are directly related to the reproductive age in which most migrants come to Costa Rica (Voorend and Robles Rivera, 2011; Sandoval, 2007; Morales and Castro, 2006;). Their "skewed" demographic presence also skews incidence data, in that for some diagnoses, younger populations will naturally have a higher weight. For example, in medical services without pathology, Nicaraguan immigrants have a higher incidence in pregnancy tests (8.7%), normal pregnancies (12.2%) and postnatal exams and attentions (12.9%). These kind of medical appointments, and those related to the urinary system, are more common in reproductive ages (Dr. Yurika Dorado Arias, interview, 2014). Combined with the difficulty to prevent these diseases because of the barriers to access to quality non-emergency healthcare services both in Nicaragua and Costa Rica, these constitute reasons why the Nicaraguan population has a slightly greater weight in these diagnoses.

5.3.4 Crowded Borders? Regional Variation

The Director of one of the biggest metropolitan hospitals recognized that the "great majority of immigrants seeking services is Nicaraguan", but says that for his hospital the share in total patients attended is not substantial. He also makes mention of another important issue, that of regional variations:

> ...well, in reality the amount of Nicaraguans here does not reach 2% of all the people we attend. But if you go to other hospitals [in regions bordering Nicaragua], for example in San Carlos or Upala, it is the other way around. They attend more Nicaraguans than Costa Ricans (Douglas Montero, Director of Hospital México, Interview, May 23, 2013).

This regional disparity is important to take into account when analyzing the data. Table 9 shows the number of hospitalizations by insurance status for some of the largest hospitals (with over 10,000 cases a year) in 2013. The selection criterion was the number of hospitalizations. Together, the selected hospitals account for 65% of all hospitalizations. All other smaller hospitals and medical centers are not included[7], save for two smaller hospitals, in Upala and Los Chiles which were included for their relatively high incidence of uninsured foreigners (of over 10%)[8], and the regions' high presence of migrant labour related to agricultural activity (Voorend *et al.*, 2013).

The data suggest several things. First, the majority of patients discharged from hospitals were covered by an insurance. Among the big hospitals, the rate of insured patients ranges between 78.6 and 92.7%. The only large hospital with a relatively low

rate of insured patients (55%) is the Women's Hospital (*Hospital de Las Mujeres*), but note that most of the uninsured are nationals (35.9%), not foreigners (9.1%).

Second, the incidence of uninsured foreigners is low, especially in those healthcare centers that account for most discharges. Second, especially in hospitals that attend populations in or from rural areas, like San Carlos, Upala and Los Chiles, the incidence of uninsured foreigners is larger: 9.4; 14.5 and 19.7%, respectively. This coincides with higher Nicaraguan migrant presence related to agricultural activity, especially in the northern regions of the country (Voorend *et al.*, 2013; Voorend and Robles Rivera, 2011).

Table 9. *Hospital Discharges by Insurance Status for Selected Healthcare Centres, 2013.*

			Non-Insured (%)	
Selected Healthcare Centres	***Total***	***Insured (%)***	*Nationals*	*Foreigners*
Total	**343,093**	**84.7**	**11.6**	**3.7**
Specialized Services	40,909	75.1	21.8	3.0
H. de Las Mujeres (Women)	12,037	55.0	35.9	9.1
H. Carlos Sáenz Herrera (Children)	15,257	80.9	18.8	0.3
Eastern Network	90,339	87.4	10.0	2.6
H. Rafael A. Calderón Guardia	33,246	92.0	5.3	2.8
H. Max Peralta Jiménez	21,731	85.2	12.9	1.9
H. Tony Facio Castro	15,937	82.5	13.7	3.8
Southern Network	62,745	85.9	10.8	3.2
H. San Juan de Dios	32,607	82.0	13.4	4.6
H. Fernando Esc. Pradilla	16,179	92.7	6.4	0.9
North-Western Network	149,100	85.1	10.2	4.7
H. México	30,260	91.1	5.4	3.5
H. San Rafael de Alajuela	22,339	83.8	11.6	4.6
H. San Carlos	15,275	82.2	8.4	9.4
H. Enrique Baltodano Briceño	17,106	78.6	16.4	5.0
H. Upala	*2,055*	*53.5*	*32.0*	*14.5*
H. Los Chiles	*1,917*	*67.4*	*12.9*	*19.7*

Source: CCSS, Área de Estadística en Salud, 2013.

Third, however, the percentage of uninsured nationals in these healthcare centers is also larger (8.4; 32.0 and 12.9%). Note that for Upala the percentage of uninsured nationals is more than double of the uninsured foreigners. What these data suggest,

rather than an overrepresentation of uninsured foreigners, is the apparent difficulties many workers in these regions face to acquire insurance. This has much to do with the informal hiring practices in agriculture (Voorend *et al.*, 2013), the most important job provider in these regions. Furthermore, with the exception of San Carlos and Los Chiles, the percentage of uninsured nationals is always higher than uninsured foreigners. However, this does not mean that nationals are uninsured more often than foreigners, just that uninsured Costa Rican nationals seek hospital services relatively more than uninsured migrants.

The 2006 data for emergency services, show a very similar picture. In Table 10, data are shown by socio-economic regions, compared to the immigrant population registered in that region. Nicaraguan immigrant incidence in emergency services is highest in those regions where Nicaraguans as a share of the total population is highest. Huetar Norte, which accounts for a substantial share of the informal population working in agricultural activities has the highest incidence (13%) which is slightly above the share in the population (11.7%).

Table 10. *Incidence in Emergency Services Compared to Migrant 'Stock' by Region, 2006.*

Region	*Nicaraguans in Total Population (%)*	*Nicaraguans in Total Number of Emergency Services (%)*
Central	4.8	4.5
Brunca	1.7	1.0
Chorotega	10.3	5.0
Huetar Atlántico	7.3	7.3
Huetar Norte	11.7	13.0
Pacífico Central	3.7	4.5

Source: Own elaboration based on CCSS, Health Statistics Area, 2006, and EHPM, INEC, 2006.

Except for the Central Pacific (*Pacífico Central*) region, the incidence in emergency services is always close to or less than the share Nicaraguans represent in the region's population. A notable case is Chorotega, where there is a significant Nicaraguan population, but where incidence in emergency services is comparatively low. This may indicate that Nicaraguans there have difficulty accessing services. In all, however, the data do not support the claims that regional variation may account for disproportionately high incidence in certain regions in Costa Rica.

5.3.5 Hospital Births: Anchor Babies?

Given the centrality in welfare magnet arguments of the idea of 'anchor babies', pregnancy services and birth deserve special attention. As was discussed in Chapter two, pregnant women and minors have undeniable access to Costa Rica's health services, and migrant women can claim residency through a Costa Rican born child.

Indeed, at first glance, the data seem to provide some evidence of higher Nicaraguan incidence in services related to pregnancies. As was already discussed, the 2006 CCSS data show an incidence of 11.3% in emergency services related to pregnancy and delivery. Again, many of these complications could have been avoided if the women involved had accessed prenatal control (Dr. Yúrika Dorado Arias, Specialist CCSS, Interview, May 9, 2014). Indeed, studies on prenatal attention show that Nicaraguan women generally have lower access to prenatal services (Spesny Dos Santos, 2015; Goldade, 2009), which helps explain why they have relatively higher shares in complicated deliveries (16.8%), hypertension during pregnancy (16%) and other types of complications (10.7%) (CCSS, Health Statistics Area, 2011).

Table 11 shows 2011 data on natural and caesarean hospital births, which confirms the higher incidence of Nicaraguan women of 16.4% and 12.7%, respectively. Compared to the 6.7% Nicaraguan share of total population in Costa Rica, these data do indeed seem to indicate an overrepresentation of Nicaraguan women, providing some basis to this part of the welfare magnet argument.

Table 11. *Hospital Births by Nationality, 2011.*

		Country of Birth		*% of Total*	
Type of Hospital Birth	***Total***	*Costa Rica*	*Nicaragua*	*Costa Rica*	*Nicaragua*
Natural	69,185	56,475	11,359	81.6	16.4
C-section	14,195	12,158	1,797	85.7	12.7

Source: Own elaboration based on: CCSS, Health Statistics Area, 2011.

However, this overrepresentation has to be analyzed more critically. First, it reflects the difference in birth rates between Costa Rica and Nicaragua. According to World Bank (2014) national data, the birth rate in Costa Rica is relatively low; 16 births per 1,000 people, while in Nicaragua this figure is significantly higher: 24 births per 1,000 people. This difference carries through with migration. Indeed, among Nicaraguan migrants in Costa Rica, the DGME (2012) calculates that for every 1,000 migrants in fertile age (15-44 years old), 100 births are registered, compared to 55 births among

Costa Rican women in fertile age. From these data, one could expect Nicaraguan women to have two hospital births for every time a Costa Rican women has one. Accordingly, their incidence in emergency services related to births could be expected to be higher than their share in the total population. Nevertheless, these patterns could still lead Costa Rican nationals to question migrant incidence in social services, and voices of welfare chauvinism.

Second, however, the birthrate differences between migrants and nationals should be analyzed more critically. Table 12 shows the same data on hospital births, on which two types of hospital birth rate per 1,000 women are calculated. The first considers the entire Costa Rican national population, and compares this to the Nicaraguan migrant population. Both natural and caesarean birth rates among Nicaraguans (39.5 and 6.2, respectively) are considerably higher than nationals (14.4 and 3.1, respectively). However, this is perhaps not an appropriate comparison.

Table 12. *Hospital Births per 1,000 Persons, by Nationality and Occupied vs. Total Population, 2011.*

Indicator	*Country of Birth*	
	Costa Rica	*Nicaragua*
Natural Births	56,475	11,359
C-section Births	12,158	1,797
Total Population in Costa Rica	3,915,813	287,766
Working Population in Costa Rica	1,670,632	205,182
Hospital Birth Rate per 1,000 Persons		
Natural Births-Total Population	14.4	39.5
Natural Births-Working Population	33.8	55.4
C-section Births-Total Population	3.1	6.2
C-section Births-Working Population	7.3	8.8

Source: Own elaboration based on CCSS, Health Statistics Area, 2011.

Considering the demographic characteristics of Nicaraguans in Costa Rica, the lion's share is in the reproductive ages between 15 and 45 years (Voorend *et al.*, 2013; Morales and Castro, 2006). Indeed, it seems more appropriate to compare such birthrates with nationals in the same age groups. Therefore, a comparison of the working populations of nationals and Nicaraguans of over 15 years is proposed, as a proxy for (re) productive ages.

Now, the ratio of Nicaraguan to Costa Rican natural hospital birth rates decreases from 2.7 times (39.5 vs. 14.4 hospital births, respectively) to 1.6 times (55.4 vs.

33.8 hospital births, respectively). Similarly, the ratio for C-section births goes from 2 to 1.2. That is, where the initial data appeared to suggest that a Nicaraguan woman is twice as likely to have a caesarean, the data based on the reproductive population suggests that the differences are much smaller.

Finally, it should be noted that the data exclude hospital births in the private system. While such services are practically inaccessible for most Nicaraguan migrants, given the high out-of-pocket expenditure such births imply, a growing share of Costa Rican middle and upper class women deliver their children in private hospitals (Martínez Franzoni and Sánchez-Ancochea, 2013). This implies that the CCSS is not registering an unknown number of national births from the private sector. Now, such hospital births under normal circumstances do not imply a cost for the CCSS, but also means that these births are not registered in the public system[9]. Therefore, the CCSS data is likely to record fewer Costa Rican births, which contributes to an overestimate of the difference in birthrates based on CCSS data between Nicaraguan and Costa Rican women.

In all, the data capturing hospital births suggests that Nicaraguan women do have higher (natural) birth rates than Costa Ricans, but that the difference is not as large as initial comparisons suggest. In any case, there is no evidence to suggest the incidence of migrants in birth related services is as high as 50% or over, as some of the interviews suggested. These data also align with qualitative research which shows that the strategy of having babies in Costa Rica to obtain legal status through the *ius soli* principle, is not as common as in countries like the US (Spesny Dos Santos, 2015; Goldade, 2011).

5.4 Conclusions

In all, the data provided by the CCSS on migrant incidence in healthcare services seem to provide very little evidence of an overrepresentation of migrants. That is, the results of an incidence analysis do not support the welfare magnet strand of disproportionally high presence of migrants in social services. It is notable that many health providers in the CCSS, especially of operational ranks, perceive migrant presence to be much higher than that suggested by the institution's own data.

Data suggest most migrants seeking healthcare contribute to health insurance, and that their incidence in health services is almost always lower than their share in the national population. Also, of the uninsured patients seeking emergency care, the bulk are Costa Rican. Only around 3% of all emergency attentions is for uninsured Nicaraguans, a percentage that has remained more or less stable over the last 10 years. Finally, while there is some regional variation and higher incidence of (uninsured) migrants in regions with more agricultural activity, the incidence of migrants in healthcare services is still often lower than their share in that region's population, or if it is

higher, the differences are not large. Notably, rates of insurance for nationals are also lower in border regions, reflecting a general difficulty in obtaining health insurance. In all, the analysis suggests there is little foundation to assume migrants are overrepresented in usage of health services.

Further research will have to confront the 'subjective' opinions of health providers with the more 'objective' data obtained from the CCSS, and question why providers think migrants overuse social services if the data suggest otherwise. While this is beyond the scope of this research, the literature suggests it may have to do with a combination of a somewhat nostalgic view of the idea of Costa Rican exceptionalism and the threat the Nicaraguan 'other' comprises (Sandoval, 2012), with persistent and ample negative media coverage of Nicaraguans (Campos and Tristan, 2009).

Notes

1 This chapter is based on a contribution for an edited volume, published by the Editorial UCR, titled *Migraciones en Centroamérica. Políticas, territorios y actores* [Migrations in Central America. Politics, territories and actors] , edited by Carlos Sandoval.

2 While this data is somewhat dated, coming from the last survey on emergency services in 2006, it is the only available data that allows disaggregation by nationality.

3 These are the number of cases attended by the CCSS in one year, meaning that the same person can attend emergency care several times.

4 These national censuses should in principle capture at least some of the undocumented migrant population, but underestimate their number given their reluctance to participate in such surveys, the difficulty to document temporal migrants and to access certain residences, such as on farm houses.

5 It is likely that the census data does not capture all irregular and temporary migrants and so it is possible that the difference between the immigrant stock and their incidence in the use of social services would only become larger.

6 As of 2005, the CCSS reports the data using the exact same categories, making the data comparable between years.

7 Thus, the numbers in the table do not add up to the total. The reason for leaving out the smaller healthcare centres is that either incidence of migrants is low, or the total number of cases attended is low, or both.

8 There are four other healthcare centres with relatively high incidence of uninsured foreigners in percentages (ranging from 21% to 45.5%), but the number of hospitalizations (11 to 19 cases in the whole year) does not justify including these medical centres.

9 What increased private healthcare implies for the long term sustainability of the public healthcare system is a different discussion. The literature suggests that more available market options may undermine projects of universalism (Martínez Franzoni and Sánchez-Anconchea, 2013).

CHAPTER 6

Sidestepping the State. Private Practices of Health Provision among Nicaraguans

6.1 Introduction[1]

Based on qualitative work, this chapter shows how Nicaraguans in Costa Rica side-step the state in order to access healthcare and other services. That is, it discusses how Nicaraguans cope with their healthcare needs, how they access public services and what they do when they do not have access to public healthcare. It argues that while public healthcare services are accessed especially for and through children, in general Nicaraguans on both sides of the border are forced to rely on very similar privatised strategies of healthcare provision, based on private providers and direct payments. In Costa Rica, access to public healthcare is limited by legal and extra-legal mechanisms, while in Nicaragua the state provides very few and qualitatively insufficient services to cover the whole population. As a result, the market is turned to for access to healthcare services, and in contexts of poverty and informality, the role of remittances is key in understanding these dynamics.

This chapter is concerned with the implementation deficit. Indeed, being formally eligible for a social service in Costa Rica is by no means a guarantee that a migrant actually can access the service (Voorend, 2014, 2015; Dobles *et al.*, 2013; López, 2012). Therefore, less formal practices of social discrimination and xenophobia, rather than the level of formal rights, are the real problem of social integration (Faist, 1994). Of particular importance for this deficit is the 'legality' versus 'illegality' divide, which in migrant anecdotes is a critical mechanism for exclusion. Thereby, the findings question more recent contributions that downplay the importance of "illegality" (Kalir, 2013; Kyle and Siracusa, 2005; Agustín, 2003), and which tend to conflate policy and political discourses around immigrant criminality and illegality. While these approaches are

concerned with not reducing immigrants to either "criminals" or "victims" and emphasizing immigrants' agency, they downplay the importance of state policies - both on paper and in practice - that heavily condition migrants' agency.

Also, this chapter considers the role of remittances as a catalyst for public and private healthcare service-seeking behavior. For a time, remittances, the international financial flows that arise from cross-border movements of people, were seen as the next panacea for development (Grabel, 2009). However, the initial fervour has slowly given way to more nuanced assessments of the potential impacts of remittances. Most important for the argument is that while the investments that remittances may foster are important, they may also represent patches "over the gaps in public funding and bank financing that have grown ever larger thanks to neo-liberal policy" (Grabel, 2009: 16). For example, when migrants or migrant associations invest in projects like schools, clinics, or hospitals, they "participate in the privatization of public services" (Hernández and Coutin 2006: 198). In Nicaragua, where coverage and quality of public services is low, remittances allow migrants and their families to compensate for the lack of access to public social services (Fouratt, 2014b), either because the latter simply do not exist or do not provide sufficient quality services, or because access to strong public social services is extremely difficult, and the market option is easier.

Methodologically, this chapter draws on data from focus group discussions (FGDs), specifically aimed at shedding light on the extent to and the ways in which migrants and their families incorporate public healthcare services in their everyday lives. Appendix 3 provides more details regarding the FGDs. Specifically, the aim was to understand how Nicaraguan migrants make use of health services, to what extent they can claim and access these services, and how important factors such as migratory status, household characteristics and labour insertion are for contesting their rights. These FGDs gave important information on whether people know their rights and which factors may inhibit their actual access to these rights.

In total, eight FGDs (of between 4-6 migrant participants) were organized with a total of 41 Nicaraguan migrants in different parts of the country. The areas were chosen based on pragmatic considerations of feasibility and the availability of contacts with migrants, or with organizations working with migrants that could facilitate contact. These small group discussions allowed for deep and personal interactions.

Participants were selected with the aim to maximize variation among participants in order to identify general trends that cut across these difference. Several of the participants were contacted during the primary survey data collection phase, after which snowballing was used to invite additional participants. While the composition of the FGDs was a result of snowballing contact with migrants, in practice they comprised

participants with different migratory status, who worked in different sectors and arrived in Costa Rica in different periods.

Furthermore, the paper selectively draws on information from Fouratt (2014b) who conducted an ethnographic study of Nicaraguan transnational families living between Costa Rica and Nicaragua. With permission of the author, a limited number of selected quotes are reproduced from this study, which included over 100 semi-structured interviews between 2009 and 2012 in both Costa Rica and Nicaragua, covering family migration histories and relationships as well as practices of remittance sending and receiving, migrants' encounters with state institutions in Costa Rica, and understandings of current immigration policies.

All FGDs were transcribed and processed using Atlas Ti. All quotes were translated by the author from Spanish to English. To ensure the anonymity of participants, real names of respondents were not used. The findings here confirm some of the patterns discussed in earlier chapters, and suggest some novel findings. Most importantly, these FGDs represent the voice of migrants themselves and provide a testimony of some of the difficulties they face in their regularization process and getting access to healthcare.

6.2 Side-stepping the State on Both Sides of the Border

Although Costa Rica's universal social services contrasts sharply with the underfunded and poor quality services in Nicaragua, in both countries, Nicaraguan families engaged in migration circumvent the state to seek services through the market in both countries. The reasons for this side-stepping, however, are context specific. In this section, access to health services of Nicaraguans on both side of the borders is discussed based on the accounts of migrants and their families.

6.2.1 Costa Rica

Migratory Status and Healthcare

Nicaraguans' practices of accessing social services as migrants in Costa Rica vary according to several factors, most notably legal status, social insurance, the presence of children, and extra-legal processes of discrimination. Legal status is a key element for not only access to social services, but integration more generally. As one Nicaraguan woman put it:

> ...here honestly without the *cédula* [residency documents], you can't do anything. [...] Without insurance, we are nothing here, without *cédula* we are nothing. Without *cédula*, they will not give you work, without *cédula* they will not give you a doctor's appointment: you need the *cédula* for everything in the entire country (Diana, FGD, Pavas, May 3, 2014).

The CCSS's stricter law enforcement (discussed in Chapter 2 and 3) is felt by the participants. Ana explained that her (Costa Rican born) grandson was not attended even when in obvious need of medical attention.

> He was in a really bad shape with high fever, and he went for a consultation and they did not attend him only because he didn't have insurance. They did not attend him. He was in really bad shape, he couldn't even walk because of the fever that he had (Ana, FGD, San Ramón, October 30, 2014).

> I had to go with my son to the pharmacy, to buy him something in the meantime. Like I say, if we are not up to date [with our insurance], we are done [...], everything is closed to us (Patricia, FGD, Pavas, August 20, 2014)

While many migrants are eligible for legal status, for example based on a first degree family relation (marriage to a Costa Rican, or as parent of a Costa Rican-born child), the process of regularization is neither straightforward, nor is legal status a sufficient condition for integration in general and for access to social services in particular. For the FGD participants, almost all employed in informal, low-wage employment, especially the high costs of regularization proved to be a high hurdle. One migrant estimated these to be as high as US $ 1,200 (Pedro, FGD, Alajuelita, January 26, 2014).

> ...it is difficult to get your papers, because look, I either pay the house or I file these papers. If I don't pay the house, they kick me out, and if I file for these papers I can't pay either [house or required documents] (Isabel, FGD, Pavas, May 3, 2014).

> ...it is the money that makes it difficult to get your legal papers (Dora, FGD, Pavas, August 20, 2014).

Sofía, a mother of three, explains just how tiresome and expensive she found the process of getting her legal documents.

> ...I went [back to Nicaragua] two years ago and I paid for the quick procedure. What 100 *córdobas*? What 100 (US) dollar? They make use of the situation. So I was there, and my three kids over here [in Costa Rica], and I was going to be there at least three days. Well that was my hope, not the week it took me and paying other procedures, and...they asked me if I had the birth certificate, if not, they would not give me the police record. So one day for the birth certificate, 100 *córdobas*. Another day for the police record, 20 dollars. Another day for who knows what, 25 dollars. Then you go to the bank here, 58 thousand *colones* plus 25 dollars for this, plus another 30 dollars for that. In all that, I had to pay for accommodation, and the authentication of documents and show them [of DGME] the return bus ticket, and then all that for my kids too (Sofía, FGD, Alajuelita, January 26, 2014).

Indeed, it is common to find Nicaraguans who have a right to residency because of their family links to Costa Rican citizens but who remain undocumented because of

the high costs of applying and obtaining the needed documents. Notably, qualitative analyses suggests that because of gendered modes of incorporation in the Costa Rican labour market, Nicaraguan women are more likely to be the last ones in their households to gain legal status or residency, making them least likely to be able to access services for themselves (Goldade, 2009). As Yolanda, an undocumented mother of four explained, her husband had residency, her 17-year-old, Nicaraguan-born daughter had residency, and her two Costa Rican born children had citizenship, but she remained undocumented:

> He got his residence permit almost three years ago, because, you know, he was working. We did it on purpose, so that he would earn better. He works in construction. In domestic work, one does not earn that well, and they don't demand [the residence permit]. In construction they do (Yolanda, Interview with Fouratt, Rio Azul, February 14, 2012)

Other participants mentioned the bureaucratic challenge of regularization. The process entails obtaining a number of documents from the country of origin, visits to several Costa Rican ministries as well as the migration offices and the bank. The 2009 migration reform has made this process even more complex and expensive, as a number of interviewees complained:

> ...it is much more difficult now than before. They ask a lot of things now (Isabel, FGD, Pavas, May 3, 2014).

> They ask a lot of papers [...] You have to go to Nicaragua to get a police record, an authenticated birth certificate that has to get stamps which cost I don't know how much money. You have to go the consulate to ask for a letter, and from there you have to file everything to see if they give it [the residence permit] to you...see if Migration feels like approving it, and if not, all that money and all that sacrifice is gone (Carolina, FGD, Pavas, May 3, 2014)

> And look how terrible it is, because if you are not insured and want to renew your *cédula*, you can't. If you don't have the *orden patronal* (social security slip), and if you are not working, how do you do it then? (Juliana, FGD, Pavas, May 3, 2014).

As was discussed in Chapter three, before 2010, migrants were able to procure insurance relatively easily as it was not conditional on migratory status. Regular and irregular residents alike could have access to healthcare services, provided they were either insured by their employers or paid the voluntary insurance fee. Combined with lenient enforcement of CCSS rules until 2011, the eligibility criteria on their own did not strongly condition migrants' access to health care, as much as the costs involved in purchasing insurance. With the Catch-22 situation created between 2009 and 2011, healthcare access has become more difficult for irregular migrants.

Further, the administrative requirements translate into a bureaucratic nightmare for migrants trying to navigate the system. Since the law's first implementation, there

have been a series of miscommunications and lack of coordination among the state institutions involved in the residency and insurance application processes (Fouratt, 2014a and b). So, for example, in 2012, an immigration lawyer working for a national NGO reported dealing with Nicaraguans' confusion over paying application fees:

> And it's not so simple as going to the bank [to pay the fee] because they don't have insurance. [...] So, they arrive at the bank and [...] can't pay because they don't have insurance. And when they go to the insurance office, they say [the migrants] can't [enrol] because their residency is expired.

As each step in the process requires migrants to fulfil other requirements, the lack of coordination among banks, the *Caja*, and immigration offices has created unresolvable conflicts.

Healthcare Access: Between Insurance and Discrimination

This lack of clarity translates in more degrees of freedom for counter clerks and other public sector employees working at the operational level to determine their own criteria for the regularization process or obtaining an insurance. There are many accounts of subtle and less subtle forms of discrimination and exclusion, even from migrants who have all their legal paperwork in order.

> You always, always find people in Migration who are angels, and there are others that woke up with their panties in a bunch, as they say. They got up on the wrong side of the bed because from the moment they arrive, it is just bitterness, bitterness. [...] It's always like, look *mamita*, this paper I can't accept, bring this, go find that and come back and then another day they want another one, because everything changed. Or they tell me go find this paper because they didn't read well the first time, [and when I bring it and say] 'here is the one the woman (clerk) asked me the last time', [they reply]: 'Nooooo, it is not that one, it is another one...go file for that one' (Carmen, FGD, Alajuelita, January 26, 2015).

While most participants acknowledge that they are generally attended if they have health insurance, some migrants interviewed also reported encountering exclusionary practices despite legally being eligible for access, in line with what previous research has suggested (Voorend, 2014; López, 2012; Goldade, 2009).

> Yes, my oldest son insures me [...] so I present his social security slip but they did not attend me. They told me, no, you need to have your own documents in order (Isabel, FGD, Pavas, May 3, 2014).

> I was with a [social security] slip for six months, and I took my documents and all, but they said they rejected me because I am a tourist (Fabian, FGD, Carrillo, October 18, 2014).

But even those who are able to gain official access through affiliation with the CCSS face obstacles to accessing healthcare services. When asked about discriminatory

practices, most anecdotes relate to the education sector, especially regarding bullying of children of Nicaraguan migrants: "there are a lot of kids that are discriminated for being immigrants" (Karla, FGD, San Ramón, October 30, 2014). When asked specifically about discriminatory practices in healthcare, participants' reactions were very diverse. One participant claimed that she "sometimes feels that the [CCSS] attends Nicaraguans better than their own ticos" (Graciela, FGD, San Ramón, October 30, 2014), but others reported feeling mistreated or discriminated against in public clinics.

> Yes, sometimes they treat you really bad, they take advantage of people in need, and they mistreat us. [...] Sure, if they can they will even hit you, and God forbid, you hit them back. Then not only are you a Nica, but you come here to play sly [*jugar de vivo*]. [...] If they throw you your papers, you just have to keep quiet and say thank you. What are you going to do? (Luz, FGD, Alajuelita, January 26, 2014).

For some migrants, interaction with Costa Rican bureaucracy in any sphere is characterized by xenophobia and discrimination.

> Most of the time, when you take out your Nicaraguan *cédula* that's it, they start to treat you bad. Wherever you go and you have to show your *cédula* you will find people making bad faces (Sarah, FGD, Alajuelita, January 26, 2014).

Further, as with legal status, incorporation into public health insurance seems to be gendered. Nicaraguan women will typically obtain a *seguro* after their spouses and children, if at all. Karina, a young mother of two small children, explained:

> Here only the two little ones and my husband have [insurance], but not me. I can get sick and all, and well, I could even be dying, but I have no money to pay for a private medical appointment (Karina, FGD, Pavas, August 20, 2014).

The FGDs suggest that adult Nicaraguan migrants face important barriers with regards to accessing services for themselves, because of stigmatization, precarious working and living conditions, discrimination, and increasingly restrictive immigration policies, including the threat of deportation (Castañeda, 2012). Carlos, who lives in Guanacaste far from the Central Valley, explained:

> That xenophobia is more present in San José, because of lineage, or ethnic group or race. There we are *morenos* [darker skinned], and are more notorious...so you see more of that [discrimination] in San José than here (Carlos, FGD, Carrillo, October 18, 2014).

Access for Children

Participants explained that they are often able to access public services for their children. Services for children are fairly easy to access for a number of reasons. First,

Costa Rican law guarantees children's access to healthcare and education regardless of immigration status. Second, many Nicaraguan migrants have Costa Rican born children, who are citizens by the *ius soli* principle. Spesny Dos Santos (2015: 5) argues these children are not considered "true Costa Ricans" and are caught in a "symbolic ambiguity [...] and will most likely always be perceived as first generation migrants". While that may be true, their Costa Rican *cédula* gives them an edge over children born in Nicaragua, at least in terms of paperwork. Mothers in particular remarked on the relative availability of services and ease of access for children.

> I had to go to the emergency ward with [my daughter] [...] and in the Children's Hospital they attended to her really well. They attended her with the condition that if she would relapse, I had to have her documents in order and especially mine. But yes, the first time they attended to her excellently (María, FGD, San Sebastián, August 7, 2014).

While they are exceptions, some anecdotes show that even for children access is not always straightforward. Sofía's daughter, Karla, was 6 months old when they migrated but they did not have her birth certificate. Because of a complicated situation with Karla's father, Sofía explains that they could never go to Nicaragua to retrieve the birth certificate, a requirement for the regularization process. Recently Karla, now 9 years old, needed medical attention which she was denied by the CCSS:

> They denied this right to my daughter in the Children's hospital. She, without residency or anything, 'illegal', was denied this right. Well, but I know we have rights too, and as soon as I mentioned that I will sue them, they sent us to validate our documents but of course, they already gave us a bad attitude. So there, no medicine for us. (Sofía, FGD, Alajuelita, January 26, 2014).

Also, children's access does not necessarily mean they are a 'vehicle' for access for adults, who often feel they are not 'deserving' of services and therefore often do not seek them unless strictly necessary. One research participant put it this way:

> It is one thing feeling that your child has the right to access medical services, it is a different thing entirely to feel that right for yourself (Pablo, FGD, Alajuelita, January 26, 2015).

Market Alternatives

Faced with difficulties in accessing public social services, many migrants find alternatives, especially with regards to healthcare. These alternatives vary across respondents, but almost always includes purchase of private services. Most common among interviewees' responses was the option of purchasing services, like medical appointment or medicine, in the private sector within Costa Rica.

> I am not insured, and when I feel bad what I do is go to a pharmacy, if I have money. And if I don't, I hang in there (Dora, FGD, Pavas, August 20, 2014).

> Sometimes I have to see with my brothers and sisters how we arrange and pay for a private clinic [for our sick mother] (Martha, FGD, Alajuelita, January 26, 2015).

In these market alternatives, migrants find strategies to overcome the high costs of private healthcare services. A relatively common option is to "have medicines sent from Nicaragua, or buy them in the black market, secretly, in the La Merced park where many Nicaraguans come" (Carlos, FGD, San Sebastián, August 7, 2014). In such cases, participants say they opt for "self-medicating and guessing what we should take" (Stefani, FGD, San Sebastián, August 7, 2014). Informal privatised practices and clandestine import of medicine from Nicaragua also seem to be common alternatives. These medicines from Nicaragua, by the way, are generally bought "in private pharmacies where one explains the case [of the patient in Costa Rica], and the doctor explains what it is [that person] can take" (Isabel, FGD, Pavas, May 3, 2014):

> What we do, is buy medicine. Some people bring from pharmacies, or some come from Nicaragua, or we go there ourselves with the recipes. Either that, or we have to pay a lot of money, the pharmacy is expensive here. [...] People from Nicaragua bring big bags [of medicine], and then [we] buy in La Merced park. [...] That is how it is, 'I have penicillin, I have this, I have that', so you just have to go there (Fabian, FGD, Carrillo, October 18, 2014).

The CCSS is avoided at all costs when migrants do not have medical insurance, and when they get sick migrants go to "the *pul* [*pulpería*: grocery store] to get a pill" (Xinia, FGD, Pavas, August 20, 2014). Respondents tell us that many people go back to Nicaragua for medical attention, either in the public system or in the much more affordable private sector there. "If you don't have an insurance here, you go back to your country" (Isabel, FGD, Pavas, May 3, 2014). As Rafaela explained in stark terms:

> We are like elephants, who, when we feel sick return to our place of birth. [...] Yes, an elephant may wander and wander and wander, right? But when he feels sick and that he's going to die, he returns to the place where he was born. And he dies there. Yes, that's how we [migrant women] are. When we get sick and we feel that is it, well, we go with terminal illnesses, because since we don't have insurance here to take care of us, when we go to the clinic they won't attend us. [...] We have 6 *compañeras* that have died of cancer, because they didn't have access to healthcare, they didn't have timely access. And so, yes, most of us choose to return to our country. To die there. (Rafaela, Interview with Fouratt, Sabanilla, November 14, 2011).

Some emergency situations, however, leave migrants with no choice but to seek medical attention in Costa Rica. In such cases, as the CCSS prescribes, migrants are presented with the invoice after receiving medical aid, and still end up having to pay. Thus, in all of the alternatives to public social services, the migrant ends up paying.

6.2.2 Nicaragua

If Nicaraguan migrants participate in privatised practices of accessing healthcare services in Costa Rica, they adopt similar strategies in Nicaragua. In Nicaragua, barriers to access are related not to citizenship status but to the poor coverage and quality of public services. While total per capita public social expenditure has increased considerably between 2000 and 2009, from US $ 91 to 157, this total spending is still less than half the amount (US $ 343) spent on healthcare alone in Costa Rica in 2009 (CEPAL, 2015).

While most social programs in Nicaragua are universal on paper, in practice they are only aimed at the poor (Martínez Franzoni and Voorend, 2012a and b). For example, between 1998 and 2005 preschool coverage (between 4 and 6 years) remained stagnant at 17% of the eligible population. Similarly, in 2015, only 38% of the population has enjoyed at least some secondary education and the country only has 3.7 physicians per 10,000 people (compared to Costa Rica's 11.1) (UNDP, 2015). Indeed, migrants in Costa Rica frequently positively remarked on the quality of services in Costa Rica, in direct contrast to what they perceived as a lack of quality services in Nicaragua.

However, during the FGDs not many participants mentioned affordable healthcare as one of the principle factors in the decision to migrate. One participant notably got annoyed at the question of whether he took Costa Rica's social services into account:

> Look, when you are in Nicaragua you don't analyze where you go, if you want to get out of where you are. You don't first analyze whether social security in Costa Rica is better than in Nicaragua. What do you think? Well, you think like this: I don't have a job, I eat one meal a day, sometimes I don't eat at all. How is it possible to think that we analyze, when all we want is to get out of there? (Ignacio, FGD, San Sebastián, August 7, 2014).

Notwithstanding the views expressed above, there are cases when access to health care drives the decision to migrate. Such cases, however, were always specific to a health condition that could not be attended in Nicaragua. For example, Fouratt (2014b) interviewed a migrant family of which one of the daughters had a heart condition that required expensive medication not covered by the Nicaraguan health care system. As poor farmers in rural Nicaragua, they could not afford the monthly expense of purchasing her medication without migrating to Costa Rica for higher wages. However, instead of purchasing medication in Costa Rica and sending it back to Nicaragua regularly, which could incur import fees, require shipping, they sent money back to their eldest daughter to purchase medication in Nicaragua. This sending back money for medicine seemed to be common practice among participants, as many noted that in the Nicaraguan health care system, the variety of free public medicines is limited.

Further, conditions in clinics and hospitals leave much to be desired. Kenneth, for example, a young man in his 20s who lived in Granada, talked about how traumatizing

it was to take his pregnant girlfriend to the hospital because of a kidney infection. At the public hospital, medical staff warned them of the chance of miscarriage because of the infection, but refused to perform an ultrasound to check on the foetus:

> So there in the hospital they do ultrasounds, but they said that one of the machines was broken and they were only doing ultrasounds for pregnancies in later stages, like 7 or 8 months. So, I didn't know what to do. I went and borrowed money to pay for an ultrasound outside [the hospital] (Kenneth, Interview with Fouratt, Granada, June 13, 2012).

In this case, Kenneth borrowed money from his employer, took his girlfriend to a private clinic for the ultrasound, then took her back to the hospital for treatment of her kidney infection. Poor treatment and lack of services is compounded by expectations that those who use public services will also make voluntary contributions of labour, money, or supplies as a requirement for accessing education, healthcare, and housing benefits.

Other families reported using remittances to pay for services ranging from ultrasounds and medication to appointments in private clinics. Frequently, remittances are used to access services for migrants' own children. However, these remittances are usually earmarked for education, food, and other necessities, so their use for emergency medical care can put a strain on caregivers' tight budgets. Marina, a grandmother raising two grandchildren in Managua while her daughter works in Costa Rica, explained that when the children get sick, she almost always takes them to a private clinic:

> When they get sick, I take them... especially since they don't have insurance here. So, I take them to a doctor. If you take them to a health center, right? A public one, and they don't take care of them, then you have to take them to a paid doctor. [...] I have to take them to a private doctor so that they pay more attention to the illness. So, all this I have to think about and is my responsibility (Marina, Interview with Fouratt, Managua, September 1, 2012).

While data is scarce, this seems to underscore previous findings. Martínez Franzoni and Voorend (2012a and b; 2011) argue that remittances play a central role in Nicaraguan families' social provisioning, and almost half of all remittances to Nicaragua are spent on medicine, housing, and education. Unfortunately, such data do not allow for a breakdown by category, but it does show that remittances are important for the funding of social provisions.

This reliance on remittances for access to social services in general and healthcare in particular, especially for migrants' own children, often creates tensions within transnational families or with caregivers in Nicaragua. Marina, for instance, reported saving every receipt for services, exams, or medicines purchased for her grandchildren in order to avoid misunderstandings with their migrant mother in Costa Rica. In other cases, when migrants are unable to send remittances, it can significantly impact children's access to healthcare. For example, Esther, who was raising her

13-year-old granddaughter reported frustration that her father had not sent money in several months, while the young girl was suffering from recurring headaches:

> I don't know. It looks like things are going badly for him economically. That's what I feel. Because Jessy has been very sick, she was in the hospital, and his help has been minimal, almost absent. The difference a CT scan would make. But that costs almost $200. And he couldn't send that. So, we haven't been able to get the scan for her (Esther, Interview with Fouratt, Managua, July 17, 2012).

A lack of remittances, then, may translate into a lack of access to healthcare, especially for children of migrants, who depend on money sent home by absent parents to meet their basic needs. While dissatisfaction with public healthcare services in Nicaragua is widespread, migration and the remittances it provides offers a way for families to side-step state sponsored services and purchase care in the private sector. However, given the high costs of such services and the general unreliability of remittances, families often combine basic care in the public sector with the purchase of medication or specialist appointments or exams in the private sector. Families who relied on such privatised provisions of care also expressed dissatisfaction with the current Nicaraguan administration, whom they saw as looking out for their own interests at the expense of the working class. It is particularly interesting that, despite the different circumstances, similar strategies for accessing health care among migrants and their families can be observed in both countries, with the use of the private sector as a strategy to deal with exclusion from the public sector (Costa Rica) and the inadequacy of public services in general (Nicaragua).

6.3 Conclusions

The analysis suggests that Nicaraguans, both in Nicaragua and in Costa Rica, rely on very similar privatised healthcare provision strategies. That is, for adult migrants in Costa Rica, or their families in Nicaragua, public social services on either side of the border play only a limited role in the provisioning of healthcare. The FGD data suggest that Nicaraguans have developed strategies that sidestep the state in order to access healthcare and other services for family members. In Costa Rica, this happens because healthcare access is not easy for migrants because of a legal impasse, high costs of regularization, bureaucracy, and extra-legal mechanisms of exclusion. In Nicaragua, this happens because public service coverage is limited, services are of a low quality, and it is perceived as making little sense to demand state-led services that were never there (Martínez Franzoni and Voorend, 2012b; 2011).

Instead, migrants in Costa Rica and their families in Nicaragua turn to the market. Privatised healthcare practices are common on both sides of the border. Interestingly,

not only do remittances from Costa Rica to Nicaragua facilitate this behaviour in Nicaragua, but also, because of the high costs of private medicine in Costa Rica, it is not uncommon to import private medicine from Nicaragua to Costa Rica, as well as black market alternatives. Similarly, depending on the severity of the case, if access to public healthcare services is impossible in Costa Rica, migrants go back to Nicaragua to seek medical attention there, often in the relatively cheaper private sector.

Ultimately, the stories of migrant participants show the relative importance of the state in setting the stage for inclusion or exclusion to social services, and the importance of the market alternative. As such, through its part as a service provider and the eligibility criteria it sets, the state plays a central role in determining integration, much in contrast to globalist authors' claim that the state and citizenship have been devalued. At the same time, 'legality' is key because, first, it is the way that institutional access is framed by law, and thereby has real impacts on migrants' lives. Second, it is key because this framework is so ingrained socially that those implementing the policies, and even those in need of services, cannot move away from this legal/illegal split.

Notes

1 This chapter is an adapted version of a co-authored paper, with Caitlin Fouratt (Fouratt and Voorend, forthcoming), who is is Assistant Professor of International Studies, California State University, Long Beach. The information from her fieldwork incorporated in this chapter is used with her permission, and references are made to Fouratt's doctoral dissertation, where the information is available.

CHAPTER 7

Migrants' Stratified Access to Public Healthcare

7.1 Introduction

This chapter continues the discussion on migrant integration in welfare arrangements beyond formal rights on paper. Based on primary survey data, it analyzes actual access to social services. This is especially important in the context of informal labour markets and contexts in which immigrants' social integration is contested (Baganha, 2000). The previous chapter already suggested that the "existence of a complex of legal rights and privileges may not dissolve discrimination and empirical inequalities" (Soysal, 1994: 134). This chapter analyses whether and to what extent Nicaraguan migrants have access to healthcare and how different groups of migrant populations differ in terms of their access to social services depending on characteristics such as their migratory status, labour insertion, and family characteristics.

Besides ethnographic accounts (Spesny Dos Santos, 2015; Fouratt, 2014b; Goldade, 2011, 2009) and legal analyses focusing on formal entitlements (López, 2012), there are only few studies with quantitative information on whether and how migrants in Costa Rica incorporate public social services in their lives (Bonilla-Carrión, 2007). This and the following chapter are motivated in part by this lack of quantitative information on migrants' real access to social services in Costa Rica, and the need to contrast qualitative work with information obtained from a larger survey to see how accurate such accounts are for the Nicaraguan population in Costa Rica. Of particular concern is the way irregular migrants, typically the most vulnerable group in a host society (López, 2012; Hujo and Piper, 2010, 2007) relate to the state, analyzing whether their 'illegality' implies a denial of all social rights and social protection. It also aims to contrast

migrant *denizens* with citizens, to see if regular migratory status in fact levels the playing field in terms of social service access between migrants and nationals.

The analysis presented in this paper is based on a survey of 795 respondents —394 Nicaraguan immigrants and 401 Costa Rican nationals. The data were collected between August and December 2013 and will be referred to as the Migration and Social Policy databas-MISOC (2013). The aim was to measure access to social services among Nicaraguan migrants in Costa Rica, and consequently examine, first, whether being an immigrant (versus a national), and second, whether legal status (regular versus irregular migrant) are important factors that determine access. The sample was designed to be representative of Nicaraguan born individuals residing in Costa Rica. Furthermore, in order to promote comparisons and to serve as a control group, Costa Ricans with similar socio-economic characteristics were included in the sample.

As is discussed in more detail in the next section, the data yield reliable and representative information on how the Nicaraguan migrant population incorporates welfare arrangements and benefits in their own welfare strategies. This is novel information, as national surveys only partially capture information for migrants. The latter do not allow for analyses of migratory status, and contain only limited information on other migratory characteristics. An International Organization of Migration survey (Acuña, Alfaro and Voorend, 2011) does gather information on migrants, but is not representative and not specifically aimed at understanding migrants' access to public social services.

The MISOC survey complements existing data from national surveys and census with a specific focus on migration and social policy access. Other sources, like the National Household Surveys, do have information for migrants related to a limited number of public social services, but do not relate this to migratory status or any other migration characteristics, besides the country of birth. As such, there is only limited information on the way migrants interact with Costa Rica's social services. In this research, the 2011 National Census is used as a reference, not only because it was conducted only two years before MISOC, but also because it is arguably the most reliable source as information was collected from door to door for the entire population residing in Costa Rica. While this does not guarantee coverage of all migrants, especially when 'illegal', it should outperform the National Surveys, which are based on a representative sampling. In contrast, the MISOC survey also allows for analyses of the determinants of access to social policy, and the importance of migratory status, discrimination, and gender dimensions in processes of exclusion.

The rest of this chapter presents the survey data, focusing especially on migratory status and access to health services. Then means are compared across different groups: nationals versus migrants, nationals versus denizens and denizens versus 'illegals', to

analyse whether these groups are statistically different, and which characteristics account for these differences.

7.2 Sample Design

The sample was designed to examine Nicaraguan migrants' access to Costa Rica's social services. Specifically, what is the effect of migratory status on access to social policy. Data were collected from different parts of the country and data collection was carried out with the aim that the findings may be generalizable to the Nicaraguan migrant population residing in Costa Rica.

The first step in the process was to determine the desired sample size. As is standard for most social-science applications, the survey design was based on a power of 0.8, a 95% confidence level and a small effect size (Cohen's d) of d=0.2. Based on these assumptions the needed sample size for the "treatment group" of Nicaraguan immigrants was calculated to be n=393 and the needed sample size for the "control group" of Costa Rican born individuals living in the same area as the migrants was the same.

Having determined the sample size, based on practical conditions such as the available budget, it was decided to field the survey in 20 districts and within these districts in 50 Primary Sampling Units (UPMs - units of between approximately 100-200 houses). In each of these 50 UPMs, a total of 8 Nicaraguan born and 8 Costa Rican born persons were randomly surveyed. In the end, valid information was gathered for 394 migrants and 401 nationals, constituting a total of 795 respondents.

To ensure that the sample was nationally representative of the Nicaraguan population in the country, the districts to be selected for the survey were identified on the basis of the "probability proportional to size sampling technique" (PPS). The probability of selecting a sampling unit (in this case a chosen geographical unit: districts) was proportional to the size of the Nicaraguan born population residing in the district (see Appendix 4 for details). PPS gives a larger weight to districts with a larger migrant population, which, combined with sampling the same number of individuals per district, yields the outcome that each Nicaraguan migrant in the population has the same probability of being sampled.

To enable comparisons with Costa Rican born individuals, a Costa Rican control group was included in the survey. Ideally, to enable useful comparisons, the control group of Costa Rican born nationals, should be similar to the immigrant group (treatment group, as it were) in terms of observed and unobserved traits, except for their migratory status. This is indeed a difficult condition to satisfy, but, to try to do this, Costa Rican born individuals living in the same neighbourhoods as the target population were sampled. Since the sampling was based on relatively small areas that contained

around 100-200 houses, this approach is likely to yield that Nicaraguan born and Costa Rican born populations shared relatively similar socio-economic features.

Data gathering took place in a period of five months between August and December 2013. It involved a team of five surveyors, who travelled together to the selected UPMs, and randomly surveyed households residing in the UPMs. The UPMs were visited on weekdays and weekends, mostly during the day. Appendix 4 provides more details on the sample design and the data collection process.

The survey questionnaire (see Appendix 5, in Spanish) comprises questions mostly designed for the respondent. However, respondents were asked about their household situation, with a limited number of questions about the household head (if the respondent was not the household head), for whom there is information on age, sex, education level and some limited information on labour insertion, such as the occupation. However, with regard to social services, respondents were asked about their own access and their children's, and otherwise, the survey was designed specifically for respondents' situations.

7.3 Descriptive Statistics

In order to introduce the survey data and to examine its credibility this section begins by comparing information generated from MISOC (2013) as compared to information obtained from other sources. Thereafter, the discussion moves on to more specific statistics on migration characteristics, health insurance and access to public healthcare and medicine. In these tables, comparisons are made between the Costa Rican nationals and Nicaraguan migrants using country of birth as the criterion for this classification. In some tables, migratory status is also used for comparison.

7.3.1 MISOC Survey versus Census Data

The survey design is expected to generate data that should be representative of the Nicaraguan migrant population in Costa Rica. Indeed, as will be discussed in this and the following sections, the survey data is comparable with 2011 census data with regard to age, household information, labour market participation, health insurance and time exposure to the host society, amongst others.

The descriptive statistics from the MISOC data (Table 13) are compared to 2011 INEC census data (Table A6-1 in Appendix 6). The migrant sample in the MISOC survey is about 3.9 years older than Nicaraguan migrants based on national census data: 39.8 years versus 35.9 years, respectively. Also, the distribution in age groups is similar to patterns observed in national data (INEC, 2011).

Table 13. *General Descriptive Statistics for Survey Data, 2013.*

Variable		*Country of Birth*	
		Costa Rica	*Nicaragua*
N		401	394
Sex	Sex Respondent-Man (%)	27.68	27.41
	Sex Respondent-Woman (%)	72.32	72.59
Age	Age Respondent (mean)	45.85	39.78
	Stand. Dev.	17.45	13.61
	Distribution (%)		
	15-24	13.22	9.64
	25-34	18.45	32.99
	35-44	16.96	23.35
	45-54	19.45	18.27
	55-64	13.97	10.41
	65-74	13.22	3.81
	75 and over	4.74	1.52
Marital Status	Married (%)	44.14	30.20
	Single (%)	22.19	22.34
	Cohabitation (%)	16.71	40.36
	Divorced (%)	8.73	3.05
	Widowed (%)	7.73	3.05
HH Head	Sex HH Head-Man (%)	57.11	60.15
	Sex HH Head-Woman (%)	42.89	39.85
	Age HH Head (mean)	50.39	41.76
	Stand. Dev.	15.53	12.84
Household	HH Size-Incl. Outside CR (mean)	3.78	4.64
	Stand. Dev.	1.77	2.11
	HH Size-Only in CR (mean)	2.60	3.09
	Stand. Dev.	1.75	1.90
	Number of Children (mean)	2.63	2.75
	Stand. Dev.	2.33	2.22
	Number of Children under 6 years old (mean)	0.25	0.38
	Stand. Dev.	0.56	0.67
	Number of Dependents (mean)	2.39	2.91
	Stand. Dev.	1.94	1.95
	Number of Contributors (mean)	1.56	1.69
	Stand. Dev.	0.93	0.99
	Family Type: Traditional (%)	35.41	55.08
	Family Type: Modified (%)	13.22	25.38
	Family Type: Single (%)	27.43	19.80
Education	Years of Education (mean)	6.10	5.33
	Stand. Dev.	3.54	3.65
	Country of Study: Costa Rica (%)	93.52	21.32
	Country of Study: Nicaragua (%)	2.49	66.75
Work	Performed Paid Work (%)	38.40	61.68
	Income Cat. Working Pop. (mean)	3.01	3.05
	Stand. Dev.	2.53	2.19
	Work Hours Main Job (mean)	39.93	44.72
	Stand. Dev.	21.02	21.40
	Worked a Second Job (%)	13.22	15.74

Source: Own elaboration based on MISOC survey (2013).

Similarly, Nicaraguan migrants in the MISOC survey average 5.3 years of formal schooling, below what INEC (2011) reports for the Nicaraguan population (6.3 years), but in line with what other studies on migrant populations in Costa Rica have reported. This suggests that an average Nicaraguan migrant only has primary education (6 years) or not even that (Voorend and Robles Rivera, 2011; Acuña, Alfaro and Voorend, 2011; Sandoval, 2008; Morales and Castro, 2006).

The MISOC survey records labour participation rates for Nicaraguan respondents of 61.7%, respectively. For migrants, the EAP based on national survey data is 51.4% (INEC, 2011), considerably lower than the MISOC survey data. This might be due to the specific definition of the EAP, which excludes paid work that is not measured by the United Nations System of National Accounts. Thus, many informal jobs might not be recorded, but are registered as paid work in the MISOC survey.

The MISOC data on household size and the number of children confirm the expectation that Nicaraguan households on average are made up of 4.64 members, exactly in line with what national survey data predict (INEC, 2011). Also, the number of children among Nicaraguans recorded in MISOC (2013) is close to the 2.63 children per woman that INEC (2011) records. More importantly, as will be discussed in the next sections, the data for migrants is in line with census data regarding migration and insurance characteristics, suggesting that the MISOC data is indeed largely representative for Nicaraguan migrants in Costa Rica. However, an important note of caution is in order. Because the survey was conducted mainly during the daytime, for logistical and safety reasons, many of the men were out working. Therefore, there is an overrepresentation of women, who either were stay-at-home moms, or worked from or near home. Just over 72% of respondents was female, significantly higher than the 52.7% female population among Nicaraguan migrants accounted for in the 2011 Census. While this overrepresentation should be kept in mind when analysing the data, it does not hinder comparisons between nationals and migrants because the female overrepresentation is identical in both samples. Also, despite this, the data compares well to other sources (eg. INEC, 2011) with regard to migrants' characteristics, which seems to suggest that there is no reason to doubt the representativeness of the data.

7.3.2 MISOC: Comparing Nationals and Migrants

The descriptive statistics also show that the migrant population and nationals in the MISOC survey are quite comparable for some variables, while others show differences. It is important to note that the Costa Rican sample is not designed to be representative of the whole Costa Rican population. Instead, it was sampled to resemble

the migrant population in the survey, and thus captures a poorer group of Costa Rican nationals. Therefore, the MISOC data for the Costa Rican sample is expected to be different from national data, and captures information for nationals with lower than average socio-economic conditions. This can be seen for example, when comparing average years of formal education, which is lower among the surveyed population as compared to national data based on the entire population. Surveyed Costa Ricans average 6.10 years of education, whereas census data report 7.7 years (INEC, 2011). Also, while the Economically Active Population recorded by INEC, of 43.2% is somewhat higher than the 38.4% recorded in the MISOC survey, average individual income of Costa Rican respondents is relatively low, between US $ 200 and 300 a month[1]. This is below the minimum wage in domestic service of approximately US $ 340, or that of a generic unskilled labourer of approximately US $ 550 (MTSS, 2015). As a result, the number of contributors to household income, however, is somewhat higher in the MISOC survey than the corresponding figure based on national data Among the Costa Ricans surveyed, an average household has 1.56 contributors, whereas national data suggest approximately 1.3 contributors. In all, the MISOC survey indeed seems to capture a poorer segment of nationals.

This is arguably most visible when comparing income between nationals and migrants. Despite migrants having longer work weeks (44.7 versus 39.9 hours) and working second jobs slightly more often than nationals (15.7% versus 13.22%), income differences between samples are not large. On average, individual income of Costa Rican and Nicaraguan respondents averaged between 200 and 300 USD per month. This explains why among Nicaraguans the number of contributors to household income is also relatively high (1.69 contributors).

As expected, in the MISOC survey, the Nicaraguan population is younger than the Costa Rican sample, and a smaller proportion lies at the extremes of the age distribution. That is, it is primarily a population in its (re)productive years. This age difference with the Costa Rican population in part explains differences in marital status. For example, it less likely for Nicaraguan migrants to be widowed. And while almost a third of migrants are married (either in Costa Rica or in Nicaragua —compared to 22.8% in INEC, 2011), this rate is higher (44%) among Costa Ricans who are generally older, and do not face legal issues to get married as might Nicaraguan ('illegal') migrants. Most Nicaraguans, though, seem to be in some kind of relationship (mostly cohabitation) and only one in five is single, similar to their Costa Rican counterparts.

Concerning years of formal schooling, MISOC data reports 6.1 years of education for nationals, meaning a difference of 0.8 years with migrants (5.3 years). This confirms a general trend captured by national data which show that nationals on average enjoy more education than Nicaraguan migrants (the difference in 2011 census data is

1.35 years, in line with expectation given it compares with a larger, better off section of Costa Rican nationals) (INEC, 2011).

The data confirm that Nicaraguan households are typically larger than nationals' households (3.78 members). This difference is partly explained by the larger number of children among Nicaraguans (2.75), than Costa Ricans (2.63). In contrast, the percentages of male and female headed households is quite similar for both groups (42.9% for nationals and 39.9% for migrants). The table also includes information for a constructed typology of families which is not captured by the national census data. It is based on the gendered division of labour: traditional (the man has paid work, the woman does not), modified (both have paid work, or only the woman has paid work), single household heads and "other" compositions, which include extended and composed families. Among migrants, traditional families account for a much larger share (55.1%), than among nationals (35.4%).

7.3.3 Migration

For many of the questions regarding the migration process in the MISOC survey there is no representative data from other sources that can be used as a reference. One aspect that has been well documented is that the bulk of contemporary Nicaraguan migration occurred in the 1990s (INEC, 2011; Sandoval, 2008; Morales and Castro, 2006).

Table 14. *Year of Arrival for Nicaraguan Migrant Population, Comparing Sources, 2011 and 2013.*

Year of Arrival	*2011 INEC Census* (%)*	*2013 MISOC Survey (%)*
N	154,818	394
Before 1970	3.0	3.8
Between 1970 and 1979	4.5	5.8
Between 1980 and 1989	10.1	14.0
Between 1990 and 1999	36.1	47.5
Between 2000 and 2009	38.2	26.4
Between 2010 and 2011/2013	8.2	2.5
Total	**100**	**100**

** This was recalculated over a total of 154,818 Nicaraguans, given that for 46.2% the INEC survey did not gather information for this variable.*

Source: Own elaboration based on INEC (2011) and MISOC (2013).

The 2011 census, for example, documents how over half the Nicaraguans in Costa Rica arrived before 1999, of which 36% arrived in the 1990s. Another 38% arrived between 2000 and 2009 (Table 14). The MISOC survey data captures a similar range of arrival years, showing that the average time exposure to Costa Rica is 19.2 years, with a standard deviation of 11.5 (see Table 15). That is, the average migrant in the survey arrived in Costa Rica somewhere around 1994 and most arrived anywhere between 1974 and 2005.

Table 15 summarizes a selected number of variables pertaining to the migration process. This is novel information and there are no other comparable sources. The survey finds that Nicaraguan respondents generally had little access to social security in Nicaragua (16.8%), and only four in ten had a paid job. In contrast, 86% of respondents had access to healthcare (and hospitals) in Nicaragua.

Indeed, migration seems to be dominated by job related motives. Respondents were asked to list the three main reasons for migrating. The lack of jobs in Nicaragua and the wage difference between Nicaragua and possible destination countries were named most often (50.1 and 47.7%, respectively). About a third mentioned both reasons, and another third mentioned at least one of them. That is, 61% of all migrants named a work related reason as a primary one.

Other reasons were less common, but children's future seems to be quite important in the decision to migrate. In total, 37.6% named children's education and 33.8% the family's access to better services such as healthcare and education. Notably, when asked why they chose Costa Rica as a destination country (and not another country), access to social services did not appear to be that important. Only 5.6% mentioned better Costa Rica's better education and 3.3% the availability of good hospitals.

There were very few cases in which pregnancy and birth were drivers of migration, providing a serious argument against the *anchor baby* idea mentioned in interviews (Chapter 5). Rather, proximity (43.9%) and the consequent lower expense of migrating to Costa Rica and not the United States for example (11.2%) seem to be the main drivers of migration. Furthermore, networks, such as family or friends in the country (36.3%) are important as well as factors relating to the labour market (23.4%): the availability of jobs (16.5%) and wage differentials (6.85). Many migrants travel accompanied (58.1%), and even more received some kind of support in Costa Rica (72.8%). This support is almost exclusively from friends (92.5%) (MISOC, 2013), showing the importance of networks in the migration process.

There is hardly any knowledge on the exact share of irregular migrants in Costa Rica, and estimates oscillate between 20 and 40 percent of the total migrant population (Karina Fonseca, Director Jesuit Service for Migrants, Interview, March 5, 2013). While the MISOC survey may have difficulty capturing data for short term temporary

Table 15. *Migration Descriptive Statistics for Survey Data, 2013.*

	Variable	*% / Mean*
N		394
Before Migrating	Social Security in Nicaragua (%)	16.8
	Paid Job in Nicaragua (%)	41.9
	Access to Hospital (%)	86.0
	Contact in Costa Rica (%)	69.0
Reason for Migrating	Lack of Jobs in Nicaragua (%)	50.1
	Wage Difference (%)	47.7
	Better Education for Children (%)	37.6
	In Need of Medical Attention (%)	4.7
	Family's Access to Public Services (including Health and Education) (%)	33.8
	For Own Education (%)	13.7
	Family Reunification (%)	30.5
	Political Reasons (%)	19.8
Reason for Choosing Costa Rica as Destination	Contact (Family/Friend) in Costa Rica (%)	36.3
	Easier to Get Paid Work (%)	16.5
	Better Pay than in Nicaragua (%)	6.9
	Proximity (%)	43.9
	Less Expensive than other Countries (%)	11.2
	Good Healthcare/Hospitals (%)	3.3
	Pregnancy, Delivery in Costa Rica (%)	0.8
	Children education in Costa Rica (%)	5.6
	Deported in Other Country (%)	0.5
Migration Process	Migrated Accompanied (%)	58.1
	Received Support in Costa Rica (%)	72.8
	Possession of Legal Documents when Migrating (%)	68.8
Time Exposure in Host Society	Years in Costa Rica (mean)	19.2
	Stand. Dev.	11.5
Legal Status in Costa Rica	Citizenship (%)	6.9
	Permanent Residence (%)	49.8
	Temporal Residence (%)	5.8
	Irregular/'Illegal' (%)	19.8
	Tourist Visa (%)	8.9
	In Process (%)	8.9

Source: Own elaboration based on MISOC survey (2013).

migrant workers who live on-farm, given the systematic approach used to gather the data it is arguably likely to yield a more reliable estimate as compared to other sources of information. The data suggest that 19.8% of Nicaraguans are irregular or 'illegal', 8.9% are on a tourist visa (which expires after 3 months) and another 8.9% are in the process of obtaining documents. The latter status should in principle not deter access to social services but in practice seems to do just that, as will be discussed in Chapter eight. In all, 62.4% have denizenship status, be it through citizenship or a permanent or temporary residence permit. The other 37.6% either is 'illegal' or has an ambiguous legal status that does not enable access to healthcare services (see Chapter 8).

7.3.4 Health Insurance

Given the principle of universal coverage that guides CCSS's health insurance, it may be assumed that every Costa Rican national is insured. However, according to INEC (2011) 12.9% of nationals are uninsured. Quite similarly, the MISOC survey suggests that 14.7% of nationals were uninsured in 2013. For migrants, in contrast, this coverage is not self-evident at all. Nationally around 34.8% are uninsured (INEC, 2011), something the survey data for this research confirms for 2013, at 36.5% (see Table 16). The similarity between the figures based on national data and on the MISOC survey highlights the reliability of the latter.

Table 16. *Health Insurance by Country of Birth, 2013.*

	Country of Birth			
	Costa Rica		*Nicaragua*	
Type of Insurance	*Absolute*	*%*	*Absolute*	*%*
Health Insurance:	342	85.3	250	63.5
Salaried Workers	76	19.0	74	18.8
Independent & Voluntary	45	11.2	43	10.9
RNC Pensioners	4	1.0	0	0.0
IVM Pensioners	49	12.2	9	2.3
Family Insurance	129	32.2	95	24.1
Insurance by the State	30	7.5	10	2.5
Other	4	1.0	2	0.5
Unknown	5	1.2	17	4.3
No Insurance	59	14.7	144	36.5
Total	**401**	**100.0**	**394**	**100.0**

Source: Own elaboration based on MISOC survey (2013).

The data also confirm the general trends with regards to the specific type of health insurance recorded by the 2011 census (see Chapter 2). First, for Costa Ricans, direct insurance is mainly through salaried work (19 versus 22.3% in 2011 census), or independent/voluntary insurance (11.2 versus 8.7% in 2011 census). Insurance by the state (7.5 versus 7.9% in 2011 census) and non-contributive pensions are also quite similar (1.0 versus 1.3% in 2011 census). Again, the data confirm the importance of the family insurance for Costa Rica's universalist health insurance coverage (32.2 versus 41.4% in 2011 census). This difference from national trends is most likely explained by the specific characteristics of the Costa Rican sample, which was selected to resemble the poorer socio-economic features of the migrant population and its more informal labour insertion. As such, while general trends with regards to insurance type are confirmed, direct and indirect insurance rates can be expected to be (slightly) lower than the national average, and the share of people without insurance slightly higher.

Second, for migrants the data also broadly confirm the census data. Family insurance is far less common among Nicaraguan migrants (24.1 versus 22.8% in census data) than nationals, and direct independent insurance is about as common at 10.9% (versus 9.6% in 2011 census data). Only few migrants are insured by the state (2.5 versus 3.0% in 2011 census data). There is a larger difference in the percentage of migrants insured as salaried workers between the MISOC data and 2011 census data: 18.8% versus 27.4%, respectively. Possibly, this relates to the 4.3% of migrants that confirmed they had health insurance, but for some reason did not respond to the question on the type of insurance. Also, given this survey was specifically aimed at migrants, it is probable that it captured a larger share of irregular migrants than the census, thus possibly explaining differences. Overall, the patterns obtained from the MISOC survey are not very different from the picture that emerges based on census data.

7.3.5 Public Healthcare and Medicine

Respondents were asked about the kind of healthcare and medicine services they seek when in need. Specifically, they were asked whether they would seek the CCSS's healthcare services or medicine when in need of such services. Thus, public healthcare and medicine access refers to perceptions of access to the CCSS's services, partly based on the respondents' previous experiences with such access. Given the survey's novelty in this respect, there is no data available from other sources that can be used to compare the results.

In Table 17, the total Costa Rican and Nicaraguan samples are compared, as well as the Nicaraguan population by legal status. Notably, Costa Ricans access public

healthcare services more often than Nicaraguans (78.8 versus 57.9%). The difference between nationals and migrants is notable and generally corresponds to the larger rates of uninsured respondents among migrants (36.5%) than nationals (14.7%). However, if only the uninsured would not have access to public healthcare, 85.3 and 63.5%, respectively, should have access to the CCSS's services. That is, there is a margin of about 6.5 and 5.4 percentage points, respectively, comprised of people with insurance but without access to public health services. In 18.5% of the cases, Nicaraguans say they will not be attended to in the CCSS, mostly related to their legal status. Among Costa Ricans who do not access public healthcare, the most common reason for not seeking the CCSS, is a preference for private healthcare (7.0%).

With regard to accessing public medicine, the gap (measured in difference in percentage points) between nationals and migrants is similar to the gap in healthcare services. However, for both populations access to public medicine (69.8 and 47.5% for nationals and migrants, respectively) is significantly lower than access to public healthcare. Interestingly, the shares of respondents without access to the CCSS's medicine do not correspond to the uninsured populations. That is, there are quite large groups of people, both among nationals and migrants, that have health insurance (and are thus entitled to public medicine) but do not get their medicines from the CCSS. Possibly, despite incurring the cost of having to buy medicine, the reason for this is the relative ease of access to medicine from private pharmacies. Private pharmacies do not require the bureaucratic hassle of getting a medical appointment and standing in line at the CCSS's pharmacies. The data seem to suggest that patients either seek medical attention in the CCSS but medicines elsewhere, confirming that private self-medication tendencies (described in Chapter 6) are not only common among migrants, but also among nationals.

Both for access to public healthcare as well as medicines, the data suggest a clear divide between denizen migrants (nationalized or residents) and other legal status. Among migrants with 'illegal' and tourist status and those with their paperwork in process, only about one in four has access to the CCSS's services, compared to about three in four for denizens. Access for those migrants with their paperwork for regularization in process is especially low, considering that in principle their status should entitle them to health insurance and services. In contrast, denizens and Costa Rican nationals seem to access public healthcare at very similar rates, suggesting that legal migratory status does stimulate migrant integration.

For medicines, the data show that denizens and nationals have very similar access, but that there are big gaps between nationals and migrants in general, mostly explained by the extremely low rates of access of non-denizen migrants. Indeed, the data show a similar divide between denizens and non-denizens. While among the former

Table 17. *Access to Public Healthcare and Medicine for Nationals, and Nicaraguan Migrants by Legal Status, 2013. (Percentages)*

	Costa Rica	*Nicaragua*					
Variable	*Total*	*Total*	*Nationalized*	*Residency*	*'Illegal'*	*Tourist*	*In Process*
N	401	394	27	219	78	35	35
Healthcare							
CCSS Free Public Healthcare	78.8	57.9	74.1	77.2	26.9	25.7	25.7
No CCSS Free Public Healthcare	21.2	42.1	25.9	22.8	73.1	74.3	74.3
CCSS Paid Healthcare	1.5	5.8	0.0	2.7	7.7	25.7	5.7
Will not be Attended	2.0	18.5	3.7	6.4	39.7	25.7	51.4
Preference for Private Healthcare	7.0	4.1	3.7	3.7	6.4	2.9	2.9
Other Reason	4.5	6.9	3.7	5.0	11.5	11.4	5.7
Unknown Reason	6.2	6.9	14.8	5.0	7.7	8.6	8.6
Medicine							
CCSS Free Medicine	69.8	47.5	66.7	64.8	21.8	14.3	14.3
Combination: CCSS and Private	2.5	3.8	11.1	4.6	1.3	0.0	2.9
Private Medicine	25.7	45.4	22.2	28.3	69.2	85.7	77.1
Pharmacy, Paid	24.9	43.7	22.2	26.5	67.9	80.0	77.1
CCSS, Paid	0.2	0.3	0.0	0.5	0.0	0.0	0.0
Contact, Paid	0.5	0.8	0.0	0.9	1.3	0.0	0.0
From Nicaragua, Paid	0.0	0.8	0.0	0.5	0.0	5.7	0.0
Other	2.0	3.3	0.0	2.3	7.7	0.0	5.7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: Own elaboration based on MISOC survey (2013).

private medicine is quite common (22.2 and 28.3% for nationalized and resident migrants, respectively), among the latter it is by far the most common option (69.2% for 'illegals'; 85.7% for tourists and 77.1% for those with their paperwork in process, respectively). Interestingly, among those migrants with a tourist status, 5.7% responded that they got their medicines from Nicaragua.

Table 18 shows public healthcare and medicine access for both samples by insurance status and type. Several things are of interest. First, among nationals, while insurance of any type warrants access to public healthcare for a considerable share of anywhere between 78.9% (among salaried workers) and 92.2% (among family insurance), there is also a considerable share of people who, despite being insured, do not access healthcare (of between 21.1% and 7.8%). For insured migrants, these rates are very similar with the exception of family insurance, suggesting that healthcare access through direct insurance is not so different among nationals and migrants.

Second, considering that a large share of national health insurance coverage is explained by family insurance, the high rate of healthcare access for nationals is promising in terms of healthcare access (92.2%). However, among migrants this rate is considerably lower (80.0%). This means that for nationals being indirectly insured almost always means accessing the CCSS's services, while for one in five migrants, family insurance does not warrant such access.

Third, among uninsured nationals, 33.9% still access free public healthcare services. This is substantially higher than among migrants (19.6%) for whom the lack of insurance almost by definition implies that the services of the CCSS are not sought. In so far these rates differ considerably between nationals and migrants, this may reflect unequal standards by the CCSS for nationals and migrants. However, it could also reflect a smaller propensity among migrants to seek such services because the uninsured migrant feels he or she has no right to them, whereas a larger proportion of nationals feels they do despite not being insured.

Finally, the data again show that larger shares of both samples do not access public medicine. Among salaried workers, 26.3% of nationals and 39.2% of migrants do not make use of their right to public medicine from the CCSS. The difference is notable, and may be explained by a stronger culture of private medicine among migrants (see Chapter 6) and the weaker perception of a right to public medicine. In contrast, among voluntary and independently insured, there is hardly any difference between nationals and migrants, but for indirectly insured again a larger share of migrants goes without access to medicines than nationals (25.3% versus 18.6%, respectively). Similarly, 88.2% of uninsured migrants does not access the CCSS's services, while among nationals this rate is 80.6%. In both cases, uninsured respondents largely avoid the CCSS's public medicine, albeit that this is more common among migrants.

Table 18. *Access to Public Healthcare and Medicine for Nationals and Nicaraguan Migrants by Insurance Type, 2013. (Percentages)*

Access to Healthcare by Country of Birth	*Salaried Workers*	*Independent & Voluntary*	*Family Insurance*	*Pensioners*	*Other and State Insurance*	*Unknown*	*No Insurance*	*Total*
Costa Rica								
Obs.	76	45	129	53	34	5	59	401
CCSS Free Public Healthcare	78.9	80.0	92.2	86.8	91.2	80.0	33.9	78.8
No CCSS Free Public Healthcare	21.1	20.0	7.8	13.2	8.8	20.0	66.1	21.2
CCSS Free Medicine	73.7	66.7	81.4	79.2	91.2	80.0	20.3	69.8
No CCSS Free Medicine	26.3	33.3	18.6	20.8	8.8	20.0	79.7	30.2
Nicaragua								
Obs.	74	43	95	9	12	17	144	394
CCSS Free Public Healthcare	81.1	79.1	80.0	77.8	91.7	70.6	19.4	57.9
No CCSS Free Public Healthcare	18.9	20.9	20.0	22.2	8.3	29.4	80.6	42.1
CCSS Free Medicine	60.8	65.1	74.7	100.0	83.3	41.2	11.8	47.5
No CCSS Free Medicine	39.2	34.9	25.3	0.0	16.7	58.8	88.2	52.5

Source: Own elaboration based on MISOC survey (2013).

An additional comparison is presented in Appendix 7. Here, urban and rural areas are compared, to account for possible differences by area of residence. The data suggest two notable things. First, for both populations, patterns regarding access to public healthcare are similar in rural and urban areas. That is, they raise no suspicion that in rural areas access to healthcare would be more difficult than in urban areas, which is a testimony to the CCSS's national coverage. Second, in rural areas public medicine is much more common than in urban areas. This is explained by the greater tendency to seek private medicine in urban areas. In fact, for migrants in urban areas, private pharmacies represent the most common way to get medicines. In rural areas, a greater share of migrants gets their medications from the CCSS, possibly simply because there are less private pharmacies.

7.3.6 Healthcare and Medicine for Children

Qualitative analysis suggests that healthcare access for adults and children are two different issues (see Chapter 6), in part because Costa Rican law grants children under 18 the unequivocal right to public healthcare. Thus, it was of interest to know whether children are able to access healthcare services and medicine, and if their access is in any way dependent on the parent's legal status.

Table 19 reports children's access to public healthcare and medicine by parent's legal status. Specifically, respondents were asked if they would take their child to the CCSS if they were in need of health services. This question was asked to all respondents who had children, also those whose children were adults by now. To ensure the data capture actual practices of health services use, the data reported in the table only refer to those 429 respondents who had children under 18 years at the time of the survey and who answered this question. Two things are noticeable. First, children's rates of access are substantially higher than for respondents themselves (compare with Table 17). This is true for nationals, but especially for migrants. Indeed, overall only less than 13% of children do not access public healthcare. Second, and more importantly, in sharp contrast with adult health services access, there are no substantial differences between averages for national (87.1%) and migrant children (87.6%). That is, it appears that the principle of universalism guiding children's healthcare coverage in Costa Rica levels the playing field between nationals and migrants. Indeed, MISOC (2013) data (not reported here) shows that 26.0% of all migrants with children under 18 did not have access to public healthcare services for themselves, but did access these services for their children.

Interestingly, while there are expected differences between children's access depending on their parent's legal status, this does not seem to condition access as much

as it did for adults: the differences between migrants with different legal status is much smaller. Residents (89.7%) and nationalized (90.0%) migrants' children access the CCSS at similar rates as nationals, and so do migrants with tourist status (85.7%) and migrants who started their regularization process (96.2%). Only among children of parents with 'illegal' status, is the coverage rate substantially lower at 77.1%. However, this is still high if compared to the health service access rate among 'illegal' adults themselves (26.9%. See Table 17). Appendix 7 shows that the general trends between urban and rural areas for children's access resemble those of their parents.

Again, the rates of children's access to medicine are generally quite a bit lower than the rates of access to public health services. On average, 76.4% and 71.7% of nationals and migrants access public medicine for their children, respectively. In contrast, 21.9% of nationals and 26.3% of migrants buys (private) medicine for their children. However, access to public medicine is substantially higher for children than for adults themselves. This is especially true for adult migrants, who access public medicine in 47.5% of the cases (see Table 17). Not surprisingly, the children of migrants with 'illegal' status access public medicine less often (58.3%). However, the differences with denizens and nationals are not as pronounced as is the case for adults, suggesting that for children, the migrant-national and denizen-'illegal' divides are not as important for social service access as they are for adults.

Table 20 reports children's public healthcare and medicine access by parent's country of birth and insurance status and type. The data confirm that patterns of health service access are very similar among nationals and migrants. Again, insurance does not seem to be such a strong determinant for children's access to public health services. In general, 87.1% and 87.6% of children with national and migrant parents accesses these services. Even among parents with no insurance, health service coverage is high among children.

While access to public medicine is generally lower, the rate for children are still quite high, and substantially higher than rates among adults. What all this suggests is that public health services and medicine are generally available to children, irrespective of their or their parents' migratory or insurance status. Coverage rates for children are high across the board, showing the strength of the Costa Rican healthcare system, and that universalist coverage for this protected group is not dependent on migration characteristics.

7.3.7 Means Test

To test whether the differences between nationals and migrants on the one hand, and 'illegal' migrants (including those with tourist status and their paperwork in process)

Table 19. *Access to Public Healthcare and Medicine for Children of Nationals and Migrant Children (under 18) by Parent's Legal Status, 2013. (Percentages)*

	Costa Rica	*Nicaragua*					
Variable	*Total*	*Total*	*Nationalized*	*Residency*	*'Illegal'*	*Tourist*	*In Process*
N	178	251	10	146	48	21	26
HEALTHCARE							
CCSS Free Public Healthcare	87.1	87.6	90.0	89.7	77.1	85.7	96.2
No CCSS Free Public Healthcare	12.9	12.4	10.0	10.3	22.9	14.3	3.8
CCSS Paid Healthcare	0.6	0.4	0.0	0.7	0.0	0.0	0.0
Will not be Attended	0.0	4.8	0.0	3.4	12.5	4.8	0.0
Preference for Private Healthcare	6.2	2.0	0.0	2.7	2.1	0.0	0.0
Other Reason	4.5	3.2	0.0	2.7	6.3	0.0	3.8
Unknown Reason	1.7	2.0	10.0	0.7	2.1	9.5	0.0
MEDICINE							
CCSS Free Medicine	76.4	71.7	70.0	74.0	58.3	71.4	84.6
Combination: CCSS and Private	1.7	2.0	0.0	3.4	0.0	0.0	0.0
Private Medicine	21.9	26.3	30.0	22.6	41.7	28.6	15.4
Pharmacy, Paid	19.1	23.1	30.0	19.9	37.5	23.8	11.5
CCSS, Paid	1.1	1.2	0.0	0.7	2.1	4.8	0.0
Contact, Paid	0.6	0.4	0.0	0.7	0.0	0.0	0.0
From Nicaragua, Paid	0.0	0.4	0.0	0.7	0.0	0.0	0.0
Other Reason	1.1	0.4	0.0	0.7	0.0	0.0	0.0
Unknown Reason	0.0	0.8	0.0	0.0	2.1	0.0	3.8
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

SOURCE: Own elaboration based on MISOC survey (2013).

Table 20. *Access to Public healthcare and Medicine for Children of Nationals and Migrant Children (under 18) by Parent's Insurance Type, 2013. (Percentages)*

Access to Healthcare by Country of Birth	*Salaried Workers*	*Independent & Voluntary*	*Family Insurance*	*Pensioners*	*Other and State Insurance*	*Unknown*	*No Insurance*	*Total*
Costa Rica								
Obs.	42	22	61	8	17	3	26	178
CCSS Free Public Healthcare	82.9	75.0	93.7	85.7	100.0	66.7	81.5	87.1
No CCSS Free Public Healthcare	17.1	25.0	6.3	14.3	0.0	33.3	18.5	12.9
CCSS Free Medicine	76.2	68.2	75.4	87.5	93.8	66.7	73.1	76.4
No CCSS Free Medicine	23.8	31.8	24.6	12.5	6.3	33.3	26.9	23.6
Nicaragua								
Obs.	52	30	53	2	6	12	95	251
CCSS Free Public Healthcare	82.7	90.0	92.5	100.0	100.0	100.0	84.7	87.6
No CCSS Free Public Healthcare	17.3	10.0	7.5	0.0	0.0	0.0	15.3	12.4
CCSS Free Medicine	67.3	76.7	73.6	100.0	66.7	66.7	72.6	71.7
No CCSS Free Medicine	32.7	23.3	26.4	0.0	33.3	33.3	27.4	28.3

Source: Own elaboration based on MISOC survey (2013).

and denizens (residents and nationalized migrants) are statistically significant, this section presents the results of means test analysis. While Appendix 8 reports means tests for a larger selection of variables, Table 21 is restricted to variables related to healthcare and medicine access, and a few other selected variables that measure some general characteristics, such as age, or characteristics related to the migration process.

First, nationals are generally older than migrants (by about 6 years on average) and denizens older than 'illegal' migrants (by about 4 years). Also, nationals enjoyed on average more education than migrants although the difference is small (0.8 years), but there is no significant difference in education between migrants with different migratory status. Regarding income category, means are significantly different in favour of denizen migrants when taking into account the whole population. However, if only the working population is considered, there are no significant differences between nationals, denizens and 'illegal' migrants, which again suggests that the Costa Rican control group was effectively selected for similar socio-economic conditions. Second, besides the time since first arrival to Costa Rica, used to measure time exposure to the host society, there is no significant difference with regards to the migration variables. On average, a denizen arrived about 7 years earlier than an 'illegal' providing some initial support for the argument that the time exposure is an important factor in migrants' social integration.

With regard to healthcare, the means tests confirm that nationals and migrants have differentiated access to healthcare insurance, services and medicines. For general access to (any type of) health insurance, migrants perform significantly worse than nationals, and 'illegal' migrants significantly worse than denizens. However, in line with the previously discussed results, insurance as salaried workers or independent/voluntary insurance is not significantly different between nationals and migrants. For all other insurance types, migrants perform significantly poorer, thus including family insurance which is very important for health insurance coverage among nationals (see Chapter 2). 'Illegal' migrants do have significantly less access to insurance as salaried workers, independent or voluntary insurance and family insurance than denizens.

Interestingly, the means test analysis confirms that denizens and nationals have very similar rates of access to public healthcare. There are no significant differences between these groups with regard to personal access. When it comes to access to healthcare for their children, denizens actually outperform nationals by 17.7 percentage points. Similarly, free public medicine is accessed more by denizens than nationals, by 11.6 percentage points. Otherwise, while factors such as age, education and income are significantly different, there is no statistical support to assume that there are differences in access to public medicine between denizens and nationals.

Table 21. *Means T-test for Selected Variables by Country of Birth, and Legal Status, 2013.*

	Means Test	*Costa Rica*	*Nicaragua*	*Denizen*	*'Illegal'*	*Diff. CR-NIC*	*Diff. CR-Denizen*	*Diff. Denizen-'Illegal'*
Selected Char.	Age Interviewee	45.85	39.78	42.13	35.87	6.074***	3.724**	6.254***
	Years Education Interviewee	6.11	5.33	5.26	5.45	0.772**	0.845**	-0.193
	Income Category Interviewee	1.61	2.14	2.35	1.78	-0.531**	-0.748***	0.577*
	Income Cat. Interviewee with Paid Job	3.01	3.05	3.22	2.75	-0.047	-0.209	0.462
	Children under 18 years old	0.57	0.75	0.76	0.74	-0.185***	-0.194***	0.0237
Health Services	Health Insurance	0.85	0.64	0.87	0.24	0.218***	-0.0171	0.627***
	Salaried Workers	0.19	0.19	0.25	0.09	0.002	-0.0584	0.160***
	Independent Workers & Voluntary	0.11	0.11	0.16	0.02	0.003	-0.0504	0.142***
	Family Insurance	0.32	0.24	0.35	0.06	0.0806*	-0.0279	0.289***
	Insurance by the State	0.08	0.03	0.03	0.01	0.0494**	0.0423	0.019
	RNC & IVM Pensioners	0.13	0.02	0.03	0.01	0.109***	0.104***	0.0149
	Other	0.01	0.01	0.00	0.01	0.0049	0.00591	-0.00269
	CCSS Free Public Healthcare	0.79	0.58	0.77	0.26	0.207***	0.0157	0.509***
	CCSS Free Pub. Health. for Child (u18)	0.45	0.60	0.63	0.56	-0.153***	-0.177***	0.0652
	CCSS Free Medicine	0.70	0.48	0.65	0.18	0.224***	0.0478	0.468***
	Private Medicine	0.26	0.45	0.28	0.75	-0.197***	-0.0196	-0.474***
	CCSS Free Meds for Children (u18)	0.37	0.48	0.49	0.47	-0.108**	-0.116**	0.0216
	Private Medicine for Children (u18)	0.11	0.19	0.17	0.22	-0.0731**	-0.0544*	-0.0495
Migration Char.	Migrated Accompanied			0.61	0.53			0.076
	Support in Costa Rica			0.78	0.77			0.0031
	Brought Legal Documents to Costa Rica			0.72	0.75			-0.0277
	Costa Rica Contact before Migrating			0.68	0.77			-0.0882
	Time in Costa Rica			21.9	14.79			7.112***

*$p<0.05$, **$p<0.01$, ***$p<0.001$

SOURCE: Own elaboration based on MISOC survey (2013).

Not surprisingly, the means for access to healthcare and medicine for adults are significantly different between nationals and migrants on the one hand, and denizens and 'illegals' on the other. Access to public healthcare and medicine is significantly higher among nationals, while the use of private medicine is significantly higher among migrants. For children, the differences are also significant, but in favour of migrants. On average, migrants make use of public healthcare and medicine for their children more than nationals, but also purchase their medicines more often. The differences between denizens and 'illegals' are also significant. Public healthcare and medicine are more often accessed by denizens, while the private medicine option is sought after more often by 'illegals'. For their children, however, there is no statistical evidence to suggest that public or private medicine usage is different between these groups.

7.4 Conclusions

The survey data confirm general trends with regards to the Nicaraguan migrant population in Costa Rica and its characteristics. A comparison of sources confirms that the data is representative for this population, especially with regards to health insurance. The survey data, however, goes well beyond existing sources to provide information on the type of access to healthcare services and relates this to other factors. The descriptive statistics and means test analysis provide important clues as to which factors facilitate and which hinder access to public healthcare and medicine.

Legal status is of critical importance to a migrant's social integration in Costa Rican society. Indeed, 'illegal' migrants (and those with tourist visa and their regularization process started but not finished) form a distinct group within the migrant population when it comes to accessing the CCSS's services, and have consistently less access than denizens and nationals. Denizenship does seem to level the playing field for many, but the data also suggest that it does not do so for all migrants. Despite having regularized their migratory status and having health insurance, some migrants fail to access public healthcare services. This underscores the idea that regularization is an important and necessary condition for access to public healthcare, but it is not a sufficient condition.

Other factors also mediate the success or failure to access public healthcare. For example, the data hint at the importance of formality of work, the presence of children in the household, the area of residence and time exposure to Costa Rican society. Each of these factors must be taken into account when analysing migrants' access to health insurance and public health services and medicines. The following chapter employs regression analysis to do just that.

Notes

1 Income is measured in categories because respondents were hesitant to reveal income information, something the categories solved. The categories comprise: Monthly income (range 1-7): *1.* Less than ₡50,000; *2.* Between ₡50,001-100,000; *3.* Between ₡100,001-150,000; *4.* Between ₡150,001-200,000; *5.* Between ₡200,001-300,000; *6.* Between ₡300,001-400,000; *7.* More than ₡400,000.

CHAPTER 8

From Social Rights to Access. Factors explaining Migrants' Access to Healthcare Services

8.1 Introduction

Based on bivariate analysis, the previous chapter displayed the link between national origin, legal status and access to social services. To push the analysis further, this chapter uses multivariate regression analysis to examine migrant access to social services. Based on the same survey data introduced in the previous chapter, this chapter examines the effect of a range of factors in determining insurance status and access to health care and medicine.

This is novel in the Costa Rican context. Most existing studies are based on qualitative research, or analyses of legal frameworks and social rights on paper, but only few use quantitative data (see Chapter 4 for a discussion). As seems to be the case in most Latin American countries, Costa Rican national survey data contain only limited information on migration processes and are not specifically designed to capture information on migrant access to social services. This seems to be standard in most other Latin American countries as well. As has been discussed in Chapters one and four, unlike this chapter, most work in the region focuses on migrant accounts based on qualitative data, or analyses of legal frameworks and what this entails for social rights on paper.

The next section of this chapter lays out the empirical specification after which the estimates are presented. A discussion section assesses the results and compares them with the previous existing findings.

8.2 Empirical Specification

To examine migrant access to Costa Rica's social (health) services (*SS*), let access be a function of characteristics of the migration process (*M*), demographic characteristics (*D*), characteristics of a person's insertion in the labour market (LM), household characteristics (*HH*) and two other control variables (*C*): geographic location and housing quality. Equation *(1)* depicts this relationship:

$$(1)\ SS=f(M,D,LM,HH,C)$$

8.2.1 Dependent Variables

To measure *SS,* three different dependent variables are proposed. First, the analysis of Costa Rica's legal framework, interviews and focus group material, suggests that a necessary condition to access public healthcare services, is to have health insurance (*I*) issued by the CCSS. Insurance is not only an indispensable requirement for accessing the CCSS's (non-emergency) healthcare services, but also a requisite for starting the regularization process by DGME. That is, for migrant integration, it is important to understand which factors might explain why some migrants have insurance, while others do not. Therefore, the first dependent variable which is scrutinized is whether an individual has health insurance.

Qualitative analyses (Chapter 6) and complementary data analysis (Chapter 7) suggest that having insurance is an important but not a sufficient condition for accessing public healthcare services or publicly provided medicines. Therefore, it is important to look at which factors explain access to public healthcare (*H*), and to publicly provided medicine (*Me*). Having insurance is probably the single most important determinant for such access, but it is necessary to go beyond insurance. Therefore, for some regressions, insurance is included as an independent variable on the right hand side (RHS) of the equation. The idea is to examine whether after controlling for access to insurance an individual's geographic origin and/or legal status continues to exert an effect on access to health care services and medicines.

Given the principle of universalism that guides healthcare coverage, it could be assumed that every Costa Rican national has insurance. If this were the case, then the analysis could have been restricted to the Nicaraguan population. However, a substantial proportion of Costa Rican nationals do not have insurance (see Chapter 2 and 7). Therefore, we provide estimates of access to *SS* based on the entire sample as well as after restricting the sample to Nicaraguan respondents. Table 22 lists and defines the dependent variables.

Table 22. *The Dependent Variables Measuring SS.*

Variable Letter	*Variable Description*	*Type of Variable*
I	Access to Health Insurance	Dummy: Do you have a CCSS health insurance? (0=no, 1=yes)
H	Access to Public Healthcare Services	Dummy: When in need, would you be able to access medical care from the CCSS? (0=no, 1=yes)
Me	Access to Public Medicine	Dummy: When in need, would you be able to access public medicine from the CCSS? (0=no, 1=yes)

Source: Own elaboration.

8.2.2 The Independent Variables

The three dependent variables listed in Table 22 are regressed on a series of independent variables, the descriptive statistics for which are provided in Chapter seven. First, and of principal concern in this research, migration characteristics (*M*) are expected to play an important role in determining access to social services. The most basic model includes a dummy variable for Nicaraguan-born respondents to test the importance of the national-migrant divide. The idea is to examine whether there is any statistical evidence of unequal access to insurance, healthcare and medicine on the basis of national origin. Furthermore, legal analyses and qualitative research suggest legal status is a key determinant. The regressions therefore include six dummies classifying respondents as either Costa Rican nationals (base category for regressions which include the Costa Rican population), nationalized migrants (base category for regressions which include only the Nicaraguan population), residents (comprising temporary and permanent residence permits and work permits), migrants with a tourist visa (meaning the respondent entered the country with a regular 90 day tourist visa which had not yet expired at the time of surveying), migrants who have their paperwork for any regular migratory status in process, and 'illegal' migrants who do not have any of these legal migratory status. For 'illegals' and tourists, a strong negative relationship is expected, as these categories in principle exclude access to public healthcare and medicine. Finally, the Law prescribes that once the paperwork for a regular migratory status in process, a migrant can obtain a (temporary and conditional) healthcare insurance from the CCSS showing a receipt to prove the conditions required by the DGME have been complied with. In principle, therefore, this category should not correlate negatively with insurance.

The categories of nationalized migrants and legal residents are expected to be positively correlated with access, but since these categories represent full denizenship on paper, their access to services should not be different from Costa Rican nationals. If, when using nationals as a basis for comparison and controlling for other factors, any of these denizenship dummies are negatively correlated with insurance, healthcare or access to medicine it may be construed as evidence that some intrinsic characteristic of being Nicaraguan inhibits access. This could be explained as discrimination on the supply side (by the institution offering the social service), or fear of seeking public medical services on the demand side (by the migrant in need of medical attention). If, in contrast, denizenship is positively correlated with any of the dependent variables it would suggest that the legal requirements for obtaining insurance translate into higher rates of insurance among denizens than nationals. Additionally, following the literature, the regressions include the time of exposure to the host society, measured as the number of years since first migration to Costa Rica, as well as an approximation of networks, measured by whether the respondent knew somebody in the country before migrating.

Second, the specification includes a vector of demographic characteristics (*D*) of the respondent, such as age and sex. In younger and older years, demand for access to healthcare and medicine might be expected to be higher than in the intermediate period. Concerning sex, focus group data and the literature suggests that women are the last in a family to get insurance, because typically they are less likely to be employed, and if they are, more so in the informal economy. This suggests that men are expected to have higher rates of insurance. That said, and as has been discussed previously, migrants in Costa Rica are typically in their reproductive years, and therefore women may be expected to have higher healthcare demands related to reproduction, and might therefore actually have higher levels of insurance. However, this expectation would be in contrast with findings from qualitative research (Fouratt, 2014b; Goldade, 2009).

Third, access to insurance, public healthcare and medicine may be expected to be correlated with labour market characteristics (*LM*). In Costa Rica, legally, formal employment should come with health insurance, be it through an employer, or for the self-employed with 'voluntary' insurance. Therefore, the formality of jobs is expected to be positively correlated with insurance and social service access. This formality is partly captured by a socio-occupational classification, which was developed on the basis of INEC's codification of occupations applied to this dataset. It follows the ILO's International Standard Classification of Occupations (ISCO-08). Based on respondents' replies, occupations were classified into one of the ISCO codes. These were then transformed into the following occupational categories: unpaid work (used as a base category for comparison), professionals and technicians, paid domestic work,

daily labourers, salespersons, farmers and fishermen, security officials, other services and finally pensioners.

The 'professional and technicians' category refers to jobs like teaching, healthcare professionals, economics, math and social sciences, that require at the very least secondary, but most often tertiary education. Similarly, technicians have followed higher education for technical professions. Daily labourers refer to salaried work almost exclusively in agriculture and construction. These jobs are salaried, but require little to no formal education. 'Salespersons' is a mixed category of any kind of sales of products. While it includes four informal peddlers, by far most (74) are classified as formal salespersons, for which a minimum level of education can be assumed. 'Farmers and Fishermen' is a category consisting of people who farm their own land or fish for a living. For this, little formal education is required. 'Security' refers to the private security services many migrants work in. While formal security services also require some certification, and often arms permits, many Nicaraguans offer their security services informally without such preparation. 'Other Services' is a residual category of diverse services including occupations such as food processing, artisanal production and personal care services. It may be expected that insurance is less common among salaried workers in sectors that are characterized by informal work, such as labour in agriculture or construction (Voorend *et al.*, 2013; Voorend and Robles Rivera, 2011). In contrast, self-employment, especially with regards to own business in agriculture or fisheries, may be expected to be correlated positively, simply because formal, registered self-employment requires health insurance. Security services could go either way, given that many migrants are informally employed in this sector, while others get jobs in security firms where insurance may or may not be part of their employment contracts. The same occupational categories are included for the household head. All the variables measuring work type or occupational sector are dummies. In regressions, unemployed/unpaid work is used as a base for comparison.

Furthermore, in all regressions, dummies are included to capture whether the following labour rights are recognized: 13th month pay; sick days; paid holidays; work risk insurance; paid overtime. While labour rights are expected to be positively correlated with insurance, healthcare and medicine access, it is unlikely that all types of rights are equally important. Additionally, regressions include the number of years of completed formal education, and the respondent's income, measured as a categorical variable. These three variables are expected to be positively correlated with the dependent variables.

Fourth, focus groups and interviews suggest that the familial characteristics and household composition (*HH*) influence access to insurance, healthcare and medicine. A dummy indicating household head is included based on the assumption that the

household head is more likely to be inserted in the labour market, and therefore more likely to be insured. Also, following feminist literature, a typology of families based on the sexual division of labour is included: traditional (the man has paid work, the woman does not), modified or reversed (both have paid work, or only the woman has paid work), single household heads and "other" compositions, which include extended and composed families. It may be expected that access to direct insurance is more likely in family compositions where household members are working. This is especially important for migrants, for whom the current legal framework makes indirect insurance extremely difficult. Furthermore, the presence of children under 18 years is probably important. On paper, children have universal access to healthcare, meaning that neither migratory nor socio-occupational status should hinder access. Both FGDs (Chapter 6) and survey data (Chapter 7) confirm that health services are accessible to children, irrespective of migratory status. This, however, does not necessarily imply children function as a catalyst for adult healthcare access. Therefore, the regressions include two dummies, one for presence of a child under six years of age, and a second for presence of a child between 7 and 18. Younger children are expected to have a stronger correlation with healthcare access because they need more regular medical care which brings people into recurring contact with the healthcare system.

For those regressions with only the Nicaraguan migrant population, the *HH* vector also includes a dummy for *Costa Rican born* children. For Costa Rican born children, the *ius soli* principle raises the expectation that adults can regularize their migratory status (and therefore access insurance) through them. Also, a dummy is included for family compositions without Costa Rican born child, but *with* a Costa Rican born adult. In theory, the presence of a Costa Rican born adult family member may also be expected to be positive, whether through the possibility of family insurance, or because of stronger networks that facilitate direct insurance.

Finally, the specification included variables to control for rural versus urban areas, and the quality of housing as a proxy for socio-economic status. The latter should be positively related to healthcare and insurance access. The former is measured as a dummy variable for urban areas, for which the expected sign is not very clear. On the one hand, it might be expected to be negatively correlated to access, because in urban areas there are more (market) options for healthcare and medicine provision as compared to rural areas. Also, hospitals are more easily accesible, as are urgency and emergency care, services that are legally provided irrespective of migratory status. This could mean that migrants may have less incentive to start regularization processes, since there is an emergency safety net. In contrast, in rural areas the smaller EBAIS healthcare centres are often the only access to healthcare services, and these only attend to insured patients, forcing migrants to get insurance. That said, in rural

areas insurance rates (especially in agriculture –Voorend and Robles Rivera, 2011) have been shown to be low among migrants (see Chapter 7).

8.2.3 Regression Models

All the outcomes are measured as binary qualitative dependent variables (*I*, *H*, *Me*), meaning that they take on a value of 0 or 1. Given the nature of the dependent variables all the regression models are estimated using a probit specification using maximum likelihood estimation. That is, the error term in the binary response model –see equation *(2)*– is assumed to have a normally distributed error term. That is, the probability of access to a particular social service is treated as a function of migratory (*Mi*), demographic (*Di*), labour market (*LMi*), household (*HHi*) characteristics and the other two specified control variables (*Ci*).

$$(2)\ Pr[SS_i=1]=Prob[\beta_{LM}\ LM_i+\beta_D D_i+\beta_{HH}\ HH_i+\beta_M\ M_i+\beta_C C_i+\varepsilon_i>0]$$

In Table 23, four different models for regression analysis are specified. These models are run for two samples: first, the entire (nationals and migrants) and the Nicaragua-only sample (NIC). The four models go from simple to more complete specifications. The logic for running different specifications is to examine the robustness of the estimates as the models become more complete. For example, model 1 only includes a dummy 'illegal' as a measure for migratory status. In the subsequent models, migratory status is further disaggregated to include the other different legal statuses. The final model, which is only run for access to public healthcare and medicine, includes health insurance on the RHS. This is to confirm the importance of insurance in ensuring access to public healthcare and medicine, and see the behaviour of other variables. If migratory status variables remain significant after controlling for insurance status it implies that migratory categories also have a bearing on access.

8.3 Regression Estimates

8.3.1 Insurance

Tables 24 and 25 provide marginal effects based on probit regressions, which measure *ceteris paribus* effects of changes of the independent variables affecting the dependent

Table 23. *Independent Variables Included in each Model.*

Vector	*Short Name*	*Model 1*	*Model 2*	*Model 3*	*Model 4*
D: Demographic	Age	X	X	X	X
	Age 2	X	X	X	X
	Sex	X	X	X	X
LM: LabourMarket	Insurance*				X
	Labour Rights Dummies	X	X	X	X
	Education	X	X	X	X
	Income Category	X	X	X	X
	Occupation: Respondent		X	X	X
	Occupation: HH Head			X	X
HH: Household	Child under 6 years old	X	X	X	X
	Child between 7 and 18 y/o	X	X	X	X
	Costa Rican Child		NIC	NIC	NIC
	Costa Rican Adult		NIC	NIC	NIC
	Family Type: Traditional	X	BASE	BASE	BASE
	Family Type: All Dummies		X	X	X
	Household Head	X	X	X	X
M: Migration	Nicaragua**				X
	Years in Costa Rica	X	X	X	X
	Costa Rican Contact	X	X	X	X
	Mig. Status: Illegal	X	X	X	X
	Mig. Status: National		BASE	BASE	BASE
	Mig. Status: Other Dummies		X	X	X
Other Control	Housing Quality	X	X	X	X
	Urban	X	X	X	X

** For regressions with I as dependent variable, I is obviously not included on the RHS.*
*** For regressions with only NIC population, this dummy variable is not included.*

SOURCE: *Own elaboration.*

variable. The first three regressions are based on the Nicaraguan respondents (1-3) while columns (4-7) are based on the total sample. Among the variables capturing demographic characteristics (*D*), there is limited statistical evidence that age affects the probability of having insurance. In regressions 1, 4 and 5, that is, the most basic models, age is positively correlated with *I*. Among migrants and the total sample, the results suggest that every year increases the probability of having insurance by 0.8 and 0.6 percentage points, respectively. In other words, based on the estimates for the total sample, all other things equal, a 40-year-old person is 6 percentage points more likely to be insured than his or her 10-year younger counterpart. While this is consistent with initial expectations, the results are not robust over regressions, as the effect is muted when controlling for other variables in the more complete models. Across all

specifications, being male is associated with a 14 to 16 percentage point lower chance of being insured as compared to women. Among migrants, the effect is similar, but the variable is hardly statistically significant.

The results do not support the idea of discrimination against Nicaraguans. Regression number 4, which excludes migratory status categories but includes a dummy for Nicaraguan respondents, shows that as compared to nationals just being a Nicaraguan does not inhibit access to insurance. The fact that the coefficient is essentially zero suggests that some Nicaraguans may have access and others not. That is, despite what qualitative data suggests, the data do not confirm that Nicaraguans are discriminated against just because of their nationality. Similarly, in the regressions where access to public healthcare and medicine are used as dependent variables, there is no evidence that being Nicaraguan limits access. Due to space constraints, these results are not reported. The coefficient and robust standard errors for the Nicaragua dummy in the Healthcare regression (-0.018; 0.069, respectively) and the Medicine regressions (0.014; 0.077, respectively) suggest there is no statistical evidence for discrimination. Therefore, the Nicaragua dummy is excluded and instead the Nicaraguan population is categorized on the basis of their migratory status (regression 1-3 and 5-7).

Indeed, of the variables in the migration vector (M), the most important are those related to migratory status. There is strong statistical evidence that the migratory status variables are important determinants of the probability of being insured. The 'illegal' and 'tourist' categories are consistently significant and have large effects. 'Illegal' migrants are between 47 and 74 percentage points less likely to be insured as compared to nationalized Nicaraguan (regressions 1-3) and between 44 and 51 percentage points less likely to be insured when compared with nationals (regressions 4-7). The effect is even stronger for Nicaraguans in the country with a tourist status. On average, consistent with expectations, being a tourist reduces insurance probability by approximately 65 to 75 percentage points.

In principle, while having denizenship status is expected to be positively correlated with I, it should not be significant in these regressions, as the base is Costa Rican nationals. That is, in principle there is no reason to assume a resident or nationalized migrant has better or worse access to healthcare insurance than a national. Accordingly, residents show no significant difference, but in regressions 6 and 7, nationalized migrants actually appear to have higher probabilities of being insured than Costa Rican nationals, by about 15 percentage points. This result is further discussed below. Despite possible access to insurance, in practice, the results show that migrants whose paperwork for regularization is in process are not insured. The 'in process' category is consistently significant and strongly negatively correlated with health insurance, the effect being quite large at about 40-60 percentage points.

Table 24. *Probit Regression Results for Insurance (I).*
(Marginal Effects Reported)

		Dependent Variable: Access to Public Health Insurance (I)						
	Model:	*(1)*	*(2)*	*(3)*	*(1a)*	*(1b)*	*(2)*	*(3)*
	Population:	*Nicaragua Only*			*Entire Population*			
	Regression #	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
D	Age	0.032**	0.009	0.006	0.013*	0.012*	0.006	0.007
		(0.011)	*(0.013)*	*(0.013)*	*(0.006)*	*(0.006)*	*(0.007)*	*(0.007)*
	Sex	-0.157+	-0.157	-0.175+	-0.157***	-0.142**	-0.164**	-0.164**
		(0.086)	*(0.100)*	*(0.099)*	*(0.046)*	*(0.046)*	*(0.055)*	*(0.055)*
M	Nicaragua				-0.074			
					(0.056)			
	Years in Costa Rica	0.008*	-0.000	0.000	0.006**	0.006***	0.002	0.002
		(0.004)	*(0.004)*	*(0.003)*	*(0.002)*	*(0.001)*	*(0.002)*	*(0.002)*
	Costa Rican Contact	-0.011		-0.009	-0.001	-0.007	0.014	0.017
		(0.063)		*(0.068)*	*(0.041)*	*(0.041)*	*(0.050)*	*(0.051)*
	Illegal	-0.471***	-0.739***	-0.744***		-0.438***	-0.510***	-0.495***
		(0.067)	*(0.093)*	*(0.095)*		*(0.067)*	*(0.094)*	*(0.095)*
	Nationalized						0.149**	0.145**
							(0.048)	*(0.045)*
	Residency		-0.172	-0.157			0.047	0.062
			(0.151)	*(0.153)*			*(0.058)*	*(0.055)*
	Tourist		-0.759***	-0.772***			-0.637***	-0.658***
			(0.053)	*(0.050)*			*(0.111)*	*(0.104)*
	In Process		-0.625***	-0.650***			-0.386**	-0.390**
			(0.121)	*(0.115)*			*(0.123)*	*(0.122)*
LM	13th Month	0.171+	0.209+	0.209	-0.058	-0.076	-0.055	-0.038
		(0.102)	*(0.117)*	*(0.136)*	*(0.093)*	*(0.095)*	*(0.103)*	*(0.104)*
	Sick Days	-0.181	-0.234+	-0.264*	-0.055	-0.065	-0.081	-0.073
		(0.125)	*(0.126)*	*(0.130)*	*(0.087)*	*(0.088)*	*(0.086)*	*(0.085)*
	Paid Holidays	0.024	-0.054	-0.056	0.112	0.115	0.083	0.087
		(0.135)	*(0.150)*	*(0.169)*	*(0.075)*	*(0.074)*	*(0.081)*	*(0.082)*
	Risk Insurance	0.456***	0.421***	0.425***	0.243***	0.250***	0.237***	0.229***
		(0.041)	*(0.047)*	*(0.046)*	*(0.033)*	*(0.032)*	*(0.035)*	*(0.034)*

		Dependent Variable: Access to Public Health Insurance (I)						
	Model:	*(1)*	*(2)*	*(3)*	*(1a)*	*(1b)*	*(2)*	*(3)*
	Population:	*Nicaragua Only*			*Entire Population*			
	Regression #	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
LM	Paid Overtime	-0.290*	-0.302*	-0.277*	-0.021	-0.018	-0.012	-0.022
		(0.126)	*(0.126)*	*(0.131)*	*(0.068)*	*(0.069)*	*(0.071)*	*(0.068)*
	Education	0.001	-0.000	-0.002	0.001	-0.001	-0.002	-0.002
		(0.009)	*(0.008)*	*(0.008)*	*(0.005)*	*(0.005)*	*(0.005)*	*(0.005)*
	Income Category	-0.002	0.016	0.023	0.008	0.006	0.020+	0.026*
		(0.018)	*(0.020)*	*(0.021)*	*(0.009)*	*(0.009)*	*(0.011)*	*(0.012)*
HH	Children under 6 years old	-0.196*	-0.236*	-0.233*	0.012	-0.018	-0.019	-0.017
		(0.088)	*(0.095)*	*(0.098)*	*(0.040)*	*(0.042)*	*(0.042)*	*(0.042)*
	Costa Rican Child	0.139	0.139	0.157				
		(0.104)	*(0.119)*	*(0.114)*				
C	Urban Area	0.005	0.054	0.080	0.007	-0.014	0.001	0.027
		(0.064)	*(0.072)*	*(0.079)*	*(0.033)*	*(0.034)*	*(0.036)*	*(0.039)*
	Housing Quality	0.023*	0.018+	0.022*	0.011*	0.010+	0.008	0.007
		(0.009)	*(0.010)*	*(0.010)*	*(0.005)*	*(0.005)*	*(0.006)*	*(0.006)*
Observations		394	394	394	795	795	795	795
Pseudo R2		0.310	0.442	0.460	0.221	0.271	0.357	0.375
Log Likelihood		-178.38	-144.28	-139.66	-329.18	-329.18	-290.39	-282.30

*Robust standard errors in parentheses: *** p<0.001, ** p<0.01, * p<0.05, + p<0.1*

SOURCE: Own elaboration.

Having a Costa Rican contact before migrating does not affect the probability of having insurance. Similarly, the time of exposure to the host society, measured by the number of years in Costa Rica, is only significant in the most basic models, but the effect disappears when other variables are included. Regressions 1, 4 and 5 suggest that a migrant with 20 years in Costa Rica has an 8 percentage point higher probability of having insurance than a migrant with 10 years in Costa Rica. The positive effect is consistent with theory but the evidence is weak.

The labour rights dummies have notable results. While having paid holidays is insignificant in all regressions, the other labour rights show significance in at least one of the regressions. Most importantly, risk insurance is consistently significant and robust, and shows a positive correlation with *I*, both in the regressions with only the Nicaraguan population as with the entire population. Among migrants, having risk insurance increases the probability of also having a health insurance by about 45 percentage points. This, of course, reflects the formality of the specific job. Among the entire population, the effect is strong, albeit a lot smaller than among migrants only: approximately 24 percentage points. Similarly, reflecting the same formality of jobs, among migrants the 13th month payment (known as *aguinaldo*) appears to positively influence the probability of having health insurance by about 17 percentage points. However, the results are almost insignificant. In contrast, among migrants with a right to paid sick days or extra work hours (paid overtime) the probability of being insured is lower. The former by about 26 percentage points, the latter by about 29 percentage points. Somewhat paradoxically, these variables pick up job *informality*, suggesting a compensatory situation in which a migrant does not have a formal contract and is not insured, but is eligible for sick days and overtime pay.

Income category is only significant in regression 7. It is positively correlated with the probability of insurance, suggesting that among the entire population every increase in income category increases the probability of insurance by 2.6 percentage points. In other words, this increase comes about when income increases by 50,000 *colones* (or about US $ 100) a month, which is the difference between the constructed categories. However, it is not significant among migrants, and only weakly so for the entire population. In contrast, there is no statistical evidence that education affects the probability of being insured.

With regard to the occupation variables, as well as the family type categories, almost none of the variables are significant. That is, there is little statistical evidence that the specific occupation or the family type affects the probability of having insurance. Similarly, the presence of children between 7 and 18 years, a Costa Rican born adult, or the fact that the respondent is the household head, seem to have no effect on *I*. Therefore, these are not discussed here, and for reasons of space, the regression

results for these variables are relegated to Appendix 9. The only variable among the household characteristics that is consistently significant among migrants (regressions 1-3) is the presence of children under 6 years. It is negatively correlated with *I*, suggesting that migrants with small children in their household have a lower probability (about 23 percentage points) of having insurance themselves. Again, while this might seem unexpected, potential reasons for this are explained below.

Finally, in accordance with the universal principle of Costa Rica's healthcare insurance, there is no evidence that the probability of being insured differs across urban and rural areas. Similarly, the housing quality index, a proxy for socio-economic status, is not systematically related to insurance status.

8.3.2 Access to Public Healthcare

Regressions 8 through 15, which estimate the effect of access to public healthcare services (*H*), are presented in Table 25. There is no statistical evidence that demographic characteristics (age and sex) affect the probability of accessing healthcare. Also, in contrast with the regressions for insurance, the labour rights dummies do not show strong results. Only risk insurance is significant in regressions 8-10 and 12-14, suggesting a positive correlation with the probability of having access to public healthcare. However, the effect disappears when insurance is introduced as an independent variable, signifying that having an insurance is one of the most important determinants of the probability of accessing public healthcare, and it captures the variation explained by the risk insurance dummy in the previous models.

Interestingly, in contrast with risk insurance, the variable measuring recognition of paid overtime among migrants actually gains significance when controlling for insurance (regression 11), suggesting that overtime pay increases the probability of healthcare access, by about 27 percentage points. This result is discussed below.

Concerning migratory characteristics, migratory status is key for healthcare access. 'Illegality' is an important determinant of public healthcare access, especially through the negative relationship with health insurance. While it falls in magnitude after one controls for insurance, 'illegality' continues to exert a negative effect on access to health care. Indeed, 20 Nicaraguan respondents had an 'illegal' migratory status but had insurance nonetheless (representing 25.6% of all 'illegals'), a possibility that was closed legally after 2012 with the CCSS's new requisite for health insurance (see Chapter 3). Similarly, 11 people had their paperwork for regularization in process, and already obtained insurance. In contrast, the negative effect for tourists is diminished and (almost) insignificant when controlling for insurance. In all, this suggests

Table 25. *Probit Regression Results for Healthcare (H).*
(Marginal Effects Reported)

		Dependent Variable: Access to Public Healthcare (H)							
	Model:	*(1)*	*(2)*	*(3)*	*(4)*	*(1)*	*(2)*	*(3)*	*(4)*
	Population:	*Nicaragua Only*				*Entire Population*			
	Regression #	**(8)**	**(9)**	**(10)**	**(11)**	**(12)**	**(13)**	**(14)**	**(15)**
D	Age	0.018	-0.002	0.000	-0.005	0.009	0.003	0.005	-0.001
		(0.011)	*(0.012)*	*(0.012)*	*(0.013)*	*(0.007)*	*(0.007)*	*(0.007)*	*(0.007)*
	Sex	0.017	0.078	0.086	0.151	-0.049	-0.065	-0.058	0.002
		(0.079)	*(0.097)*	*(0.099)*	*(0.107)*	*(0.047)*	*(0.056)*	*(0.056)*	*(0.058)*
M	Years in Costa Rica	0.007*	0.000	0.001	0.001	0.006***	0.003	0.003	0.003
		(0.003)	*(0.003)*	*(0.003)*	*(0.003)*	*(0.001)*	*(0.002)*	*(0.002)*	*(0.002)*
	Costa Rican Contact	-0.022	-0.021	-0.011	-0.011	-0.016	0.008	0.013	0.011
		(0.059)	*(0.065)*	*(0.066)*	*(0.067)*	*(0.048)*	*(0.056)*	*(0.056)*	*(0.056)*
	Illegal	-0.365***	-0.477***	-0.463***	-0.232+	-0.369***	-0.433***	-0.427***	-0.219*
		(0.063)	*(0.100)*	*(0.104)*	*(0.132)*	*(0.064)*	*(0.082)*	*(0.083)*	*(0.096)*
	Nationalized						-0.017	-0.021	-0.099
							(0.103)	*(0.103)*	*(0.112)*
	Residency		0.029	0.040	0.041		0.057	0.064	0.024
			(0.110)	*(0.112)*	*(0.111)*		*(0.064)*	*(0.064)*	*(0.072)*
	Tourist		-0.473***	-0.492***	-0.199		-0.435***	-0.442***	-0.150
			(0.100)	*(0.096)*	*(0.163)*		*(0.106)*	*(0.105)*	*(0.133)*
	In Process		-0.472***	-0.462***	-0.318*		-0.451***	-0.450***	-0.318*
			(0.100)	*(0.106)*	*(0.149)*		*(0.098)*	*(0.098)*	*(0.129)*
LM	Health Insurance				0.579***				0.552***
					(0.062)				*(0.047)*
	13th Month	0.026	0.063	0.088	0.020	-0.049	-0.013	-0.014	-0.006
		(0.128)	*(0.148)*	*(0.141)*	*(0.147)*	*(0.095)*	*(0.099)*	*(0.099)*	*(0.096)*
	Sick Days	-0.120	-0.148	-0.137	-0.042	-0.062	-0.059	-0.052	-0.023
		(0.130)	*(0.133)*	*(0.131)*	*(0.135)*	*(0.086)*	*(0.088)*	*(0.087)*	*(0.083)*
	Paid Holidays	0.014	-0.073	-0.085	-0.062	0.109	0.054	0.062	0.034
		(0.135)	*(0.155)*	*(0.150)*	*(0.151)*	*(0.086)*	*(0.097)*	*(0.095)*	*(0.093)*
	Risk Insurance	0.313***	0.271**	0.257*	-0.007	0.164**	0.158*	0.143*	-0.005
		(0.086)	*(0.103)*	*(0.108)*	*(0.141)*	*(0.060)*	*(0.065)*	*(0.067)*	*(0.077)*

		Dependent Variable: Access to Public Healthcare (H)							
	Model:	*(1)*	*(2)*	*(3)*	*(4)*	*(1)*	*(2)*	*(3)*	*(4)*
	Population:	*Nicaragua Only*				*Entire Population*			
	Regression #	**(8)**	**(9)**	**(10)**	**(11)**	**(12)**	**(13)**	**(14)**	**(15)**
LM	Paid Overtime	0.094	0.143	0.139	0.271**	0.039	0.049	0.047	0.078
		(0.104)	*(0.103)*	*(0.103)*	*(0.092)*	*(0.063)*	*(0.063)*	*(0.065)*	*(0.063)*
	Education	0.002	0.004	0.003	0.007	-0.001	-0.001	-0.000	0.001
		(0.008)	*(0.009)*	*(0.009)*	*(0.010)*	*(0.006)*	*(0.006)*	*(0.006)*	*(0.006)*
	Income Category	-0.027	-0.017	-0.012	-0.022	-0.028**	-0.014	-0.012	-0.022
		(0.017)	*(0.023)*	*(0.023)*	*(0.024)*	*(0.010)*	*(0.014)*	*(0.014)*	*(0.014)*
HH	Children under 6 y/o	0.097	0.112	0.110	0.231**	0.055	0.054	0.054	0.083+
		(0.077)	*(0.083)*	*(0.084)*	*(0.087)*	*(0.047)*	*(0.048)*	*(0.047)*	*(0.049)*
	Costa Rican Child		-0.012	-0.024	-0.102				
			(0.103)	*(0.102)*	*(0.120)*				
C	Urban Area	-0.030	0.045	0.036	0.001	-0.007	0.054	0.060	0.061
		(0.062)	*(0.070)*	*(0.075)*	*(0.079)*	*(0.039)*	*(0.043)*	*(0.045)*	*(0.046)*
	Housing Quality	0.024*	0.022*	0.019+	0.014	0.014*	0.013*	0.013*	0.012+
		(0.009)	*(0.010)*	*(0.010)*	*(0.011)*	*(0.006)*	*(0.006)*	*(0.006)*	*(0.006)*
	Observations	394	394	394	394	795	795	795	795
	Pseudo R2	0.150	0.254	0.273	0.381	0.135	0.200	0.209	0.325
	Log Likelihood	-227.68	-199.92	-194.63	-165.89	-428.24	-395.95	-391.62	-333.94

*Robust standard errors in parentheses: *** p<0.001, ** p<0.01, * p<0.05, + p<0.1*

SOURCE: Own elaboration.

that healthcare access depends first and foremost on insurance, and as seen before, insurance depends on migratory status. As expected, denizenship categories do not show any significant differences as compared with nationalized migrants (8-11) or nationals (12-15). Finally, migrants with their paperwork in process have consistently and significantly lower probabilities of having access to healthcare, while technically this should not be the case.

Having a Costa Rican contact prior to migrating does not affect the probability of accessing public healthcare. Similarly, it appears that the time spent in Costa Rica does not have a strong bearing on access to healthcare. Finally, there is some statistical evidence to support the claim that migrants access healthcare services through their children. After controlling for insurance (regression 11), having a young child increases the probability of using public healthcare by about 23 percentage points. This is an interesting finding in light of the qualitative analysis, which was unclear on whether children serve as catalysts for adult access. There seem to be no statistically significant differences between urban and rural areas with regards to public healthcare access probabilities. This probability does increase with the housing quality index, however, showing a 1.3 percentage point increase for every point on the index for the entire population. Between a person who lives in the poorest quality house (3 points) versus one who lives in the highest quality house (9 points), there is a 7.8 percentage point difference in *H.* Among migrants, this effect is higher but loses significance when controlling for insurance.

8.3.3 Access to Public Medicine

Finally, public medicine seeking behaviour in general terms behaves similar to healthcare access. For this reason, the regressions results are reported in Appendix 9, although the most noteworthy results are briefly discussed here.

As with healthcare access, insurance is a key determinant of access to public medicine, with a similar effect size of around 54 percentage points. Similarly, three of the other labour rights dummies are significant, namely sick days, risk insurance and 13th month. Only the last, however remains statistically significant when healthcare insurance is introduced in the regressions. The recognition of a 13th month among migrants is negatively correlated with *Me*, decreasing it by around 35 percentage points. This negative and large effect is most likely related to the increased purchasing power resulting from the payment, making it more likely to access private medicine. Sick days also correlates negatively among migrants, but loses its already weak significance when insurance is included. Risk insurance is significant and positive, for both

populations, but captures the formality of work effect of insurance and does not hold significance on its own.

The presence of children under 6 years of age is significant and positive in the regressions reported in Appendix 9 using the entire population. This presence increases the probability of accessing public medicine by about 12 percentage points. However, this is not true for the regressions with Nicaraguan population. In contrast, the migratory categories behave exactly as expected and as they had with regards to public healthcare. 'Illegal' migrants and tourists have a significantly lower probability of accessing public medicine, as do migrants who have their paperwork in process.

Noteworthy is that, for the entire population, living in urban areas decreases the probability of access to public medicine by anywhere between 8 and 14 percentage points. This hints at more private medicine seeking behaviour in urban areas. Interestingly, this effect is not significant for migrants, which suggests that migrants' medicine access is not that different between rural and urban areas.

8.4 Factors Explaining Migrant Access to Healthcare

The results of the regressions in many ways confirm and in some ways contradict qualitative work on migrant inclusion and access to social services, in particular healthcare. First, where qualitative analysis has suggested clear discrimination against migrants "and also reveals that the 'national' versus 'migrant' categories are [...] often more determinant than 'insured' versus 'uninsured'" (Spesny-Dos Santos, 2015: 7), something also suggested by the qualitative part of this research, regression analysis does not confirm this. The regressions included a dummy variable for a respondent being from Nicaragua. However, even when migratory status was not included in the model, there was no significant statistical evidence to support this claim. Instead, migratory status categories were included, which could still provide evidence of discrimination if those with denizenship were less able to access social services as compared to nationals. However, this was not the case.

Instead, the regression results clearly suggest that access to public healthcare and medicine depends first and foremost on insurance, and insurance depends on migratory status. Tourists and 'illegal' migrants have difficulty accessing healthcare insurance, and as a result, have considerably less access to public healthcare and medicine. This is an expected result, given the greater restrictions on access to healthcare insurance imposed by the CCSS as of 2012.

That said, 'illegality' also has explanatory power even after controlling for insurance. This means that even if an illegal migrant has healthcare insurance —a possibility that drastically reduced after the CCSS's stricter law enforcement starting 2012— the

fact that that person lacks legal documents showing denizenship status hinders his or her access to public healthcare and medicine. The general expectation that a denizen in Costa Rica has the same type of access to social services as a national is confirmed in the regressions. However, interestingly, the results suggest that nationalized migrants are more likely to have insurance than Costa Rican nationals. This is explained partly by the legal requirements for nationalization for migrants (which include direct insurance from the CCSS) but also reflects a share of about 14 percent of nationals that do not have insurance. It also underscores national census data (INEC, 2011) which confirm that migrants have higher relative rates of direct insurance. Interestingly, migrants with their paperwork in process consistently perform worse with regards to social service access. This, in theory, should not be the case. In Chapter three, it was discussed that Supreme Court rulings issued that the DGME should issue temporary permits which allow migrants to proceed with affiliation to the CCSS's insurance, after which the regularization process can be continued. The regression results confirm the suspicion that in practice this is unlikely to happen.

From the literature and qualitative work, other factors were also expected to be of importance. Specifically, time exposure in the host society, geographic exposure and social exposure (Danzer and Ulku, 2008) are all expected to have a bearing on migrant integration. Furthermore, from interviews and focus group material, the presence of children in the household, through the undeniable universalist coverage of healthcare of minors irrespective of nationality and migratory status, was expected to positively affect their parents' access to insurance, healthcare and medicine. This was especially expected to be true for children born in Costa Rica, who could function as "anchor babies" through which regularization and insurance are easier to obtain because of the *ius soli* principle. Their presence may positively influence other household members' access to social services as well.

The regression results showed only weak evidence for the importance of time exposure to the host society, measured as the number of years in Costa Rica since the person's first migration. The positive sign and size of the effect were consistent with theory but the results were only significant in the most basic models. The inclusion of other controls led to a loss in statistical significance. Given that the literature and focus group data confirm the complicated bureaucratic and costly procedures for regularization and health insurance, these might discourage migrants in the pursuit of obtaining legal status, meaning that longer time exposure does not necessarily lead to better access to social services.

Overall, geographic exposure did not seem to have an important effect. In line with the universal principle of Costa Rica's social insurance and healthcare services, the data analysis suggests there are no significant differences between access to insurance

and healthcare in rural and urban areas. This, in and of itself, is promising for migrants' social integration because agriculture, one of the principle sectors in which they find work, takes places mainly in rural and semi-urban areas. However, for the total sample, public medicine access in urban areas is significantly lower than in rural areas. Interestingly, this result is only found when including the Costa Rican control group in the regressions, which suggests two noteworthy findings. First, assuming people in urban areas have similar medicine needs as people in rural areas, the former find other options to cater to these needs. That is, private pharmacies fill much of that need. This is because in the city, this market option —as Martínez Franzoni and Sánchez-Ancochea (2013) put it— is more available than in rural areas. Second, the fact that this result is not found for migrants, means that their medicine seeking behaviour is not so different in the city as compared to rural areas. Building on migrant accounts (Chapter 6) and survey data (Chapter 7), this implies that among migrants it seems common practice to either buy medicine on the market or "forego" any health situation that would otherwise imply medicine-seeking behaviour, irrespective of the specific geographical area of residence. This is because of difficulties accessing public medicine, combined with the perception of not being eligible for these services among migrants, or simply because private pharmacies are faster and easier.

Social exposure is quite complex, and can be understood in many dimensions. In this research, it was measured as having a contact in the host country before migrating. The other dimensions of social exposure, such as family ties, or labor market integration were captured by other variables. Having a contact before migrating implies access to valuable information not only about work opportunities, (initial) accommodation, but also on the nitty-gritty of the requisites of social integration. However, the regressions did not confirm this, something that also came out of focus groups. It seems that networks are important for making decisions on when and where to migrate, but with regards to obtaining insurance, public healthcare and medicine access, they appear less important. This makes sense, given the individualized and bureaucratic, and most importantly costly process of regularization in Costa Rica. Together with the fact that for migrants there is, *de facto*, no CCSS family insurance as per 2012, this might explain why contacts in Costa Rica do not determine access to social services.

The presence of children shows mixed results. Among migrants, the presence of children under 6 reduces the probability of health insurance of the respondent. This possibly underscores the idea that respondents with small children might have less incentives to insure themselves, but may actually access healthcare services through their children. When the Costa Rican control group is included in the regressions, the presence of children under 6 consistently and positively affects the probability

of accessing public medicine, suggesting that public medicine seeking behaviour is partly explained by small children. This should not be a surprise, as the CCSS and the EBAIS have very well developed and universal child health monitoring programs. Anecdotal evidence suggests, for example, that even many middle and high class Costa Rican families who see family doctors and paediatricians for their small children in the private sector, still make use of public vaccination and control programs. This behaviour, however, is more common among nationals than migrants, as for the latter the effects are not significant. In contrast with evidence from interviews, the data do not support the idea that the presence of a Costa Rican born child positively affects access to insurance, public healthcare or medicine. That is, the "anchor baby" argument is put into question.

Furthermore, while the occupational categories seemed to have less explanatory power by themselves, the type of economic integration does play a crucial role in social integration. For migrants, the informality of sectors such as agriculture, informal services, and security hinders their access to health insurance, healthcare and medicine. Especially the recognition of labour rights as measures of job formality capture this effect. The results, however, show that not all labour rights carry the same importance with regards to social integration. The effect of having risk insurance is positive and significant, but it is no longer significant in the regressions for healthcare and medicine access when insurance is included on the RHS. In contrast, recognition of a 13th month is also positively related to insurance. These two labour rights are typically, although not necessarily, part and parcel of formal employment which include health insurance from the CCSS as well. They seem good measures for job formality.

Paradoxically, the recognition of some labour rights actually captures job *informality*. Being paid sick days, for example, is negatively correlated with insurance among migrants. Similarly, being paid overtime correlates negatively with insurance. Qualitative work suggests that these payments might work as a 'compensatory' measure by employers who prefer to pay for sick days in the event of illness and overtime but then do not provide their migrant workers with health insurance. Finally, the negative effect of being paid a 13th month on public medicine access most likely reflects the greater purchasing power of migrants being recognized that labour right, making private pharmacies a more viable options. This privatisation of medicine is a clear finding in previous chapters as well and it should come as no surprise therefore that there is some statistical evidence for increases in income actually leading to more private medicine seeking behaviour. In line with these findings is that in urban areas, the use of public medicine is relatively lower than in rural areas, reflecting again the stronger 'market option' of private medicine.

8.5 Conclusions

Regression analyses demonstrate that migrants' access to social services is mediated by many factors, but principally by the state's legal recognition, both of migratory status as well as health insurance. The formality of labour insertion is another crucial factor. These have in common that for successful integration, or access to social services more specifically, a migrant has to acquire a 'formal' position in society, that is, legally recognized.

However, as this research has shown, structural and institutional processes of exclusion make this acquisition of 'formality' quite challenging for many migrants. The insertion in secondary labour markets relates to a structural demand for low skilled migrant labour, often employed informally and without health insurance. Similarly, the institutional framework creates boundaries to migrant inclusion by making it difficult not only to regularize migratory status, but also to acquire health insurance.

This analysis demonstrates that such boundaries are problematic for migrant inclusion. If the state truly aspires to respect human rights and create the conditions for inclusion, it should revise its migration policy and make regularization of migrants more accessible. However, the state should also go beyond the exclusive focus on regularization for example by enforcing stronger regulation on employers in migrant labour markets. Currently, intentionally or not, policy serves as a tool to maintain a supply of 'illegal' migrants in function of the structural demands of certain key sectors of the economy.

CONCLUSIONS

With its long tradition of strong and universal social policy, on the one hand, and relatively high immigration, Costa Rica presents a unique case in the South to study the interplay between migration and social policy. This research empirically contributes by examining the state's openness to migration from Nicaragua, and the extent to and the ways in which migrants access social services. It also speaks to larger debates on universalism in social policy, social exclusion and welfare migration. This concluding chapter discusses both the implications for a country-specific policy debate as well as the contributions of the Costa Rican case to the international literature with which this research engages.

Notes for a Public Policy Debate

In Costa Rica, social security and public healthcare are under financial strain and a common perception is that migrants, especially from Nicaragua, are to blame. However, this research has shown that migrant access to healthcare is far from self-evident, and that it is mediated by legal and extra-legal measures of exclusion.

The research presented here showed that the Costa Rican state has been taking actions to limit migrants' access to public healthcare services at a time when voices of welfare chauvinism are louder than before. This clamour rose initially because of economic slowdown following the international financial crisis of 2008, but especially because of the 2011 financial crisis in the country's healthcare and most important social institution, the *Caja Costarricense del Seguro Social*. Such limitations were deployed through stricter law enforcement of previously lenient policies, in particular

the provision of services without health insurance. Compounded in its latest migration law reform by the creation of new legal requisites for regularization that now stipulate health insurance as a crucial requisite. Consequently, since 2009, the CCSS has had an active role in migration policy, becoming a principle tool for migration control.

Paradoxically, the new legal barriers for regularization and health insurance (Chapter 3), and therefore healthcare access, were created in the same 2009 migration reform in which the Costa Rican state for the first time explicitly acknowledged international human rights frameworks and recognized the importance of integration of the migrant population in society. As one of the most important contributions, Chapter three shows the inventiveness of states to subscribe, in discourse, to international paradigms and norms related to human rights, but in practice circumvents them. Empirically valuable is the finding that this inventiveness passed through deliberate and explicit interaction between two of the state's most important institutions for migrants' social integration: the CCSS and DGME.

The ensuing legal Catch-22 situation created by the interaction between social and migration policy made it practically impossible for migrants without a regular migratory status to get insured and to legalize their migratory status. This has important implications for how universalism applies to migrants. The specific requisite that each migrant wanting to regularize his or her status needs personal, *direct* health insurance limits access to the principle mechanism that makes Costa Rica's health insurance coverage universalist among nationals: family insurance. This is an institutional process of exclusion, by which the state makes a thoughtful move to limit for migrants the same principle of universalism that guides social policy for its citizens. Less formal processes of exclusion make access to health services even more difficult. Migrants testify to encounters with everyday practices of discrimination (Chapter 6) and counter clerks' personal interpretations of laws to the detriment of migrants' healthcare access, even those whom have health insurance.

In all, Costa Rica's current migration policy does not stimulate regularization. In fact, state policy allows for an extreme form of differential exclusion (Schierup *et al.*, 2006), accepting the covert exploitation of the lack of rights and vulnerability of many migrants. This is in direct conflict with the state's (official) mandate to regularize as many migrants as possible so they contribute to social security and contrasts with the 'refreshing' integration discourse in Costa Rica's current migration law, the creation of multi-stakeholder platforms and the creation of an integration department in the DGME following the law's approval.

In line with what Domenech (2011) finds for Argentina, Costa Rica's 'new migration policy' has been structured according to the principles of 'migration management' —to ensure an ordered and predictable and therefore more *manageable* immigration

flow which is assumed to go hand in hand with the protection of migrants' human rights. Fundamental in this view is control over irregular (or 'illegal') migration. It is thus not surprising that Costa Rican state policy aims, at least formally, to diminish irregular migration. However, the findings here underscore previous work (Fouratt, 2014a) arguing that in fact migration policy follows a traditional perspective of control and securitization, but framed in a human rights rhetoric that serves to legitimize troubling aspects of this perspective (Chapter 2). Instead of a real commitment, the integration discourse, steadfast in the recognition of human rights, seems to be a necessary condition for the law's general acceptation and implementation.

'Illegality' then holds central importance for migrants' social inclusion because the state sets this as a rule. Quantitative and qualitative analysis confirm this and show it is possibly the most important determinant in a migrant's social inclusion (Chapter 6-8). In its absence, market options play an important role for meeting healthcare demands among migrants. Survey data confirms that the option of private medicine is much more common among migrants (Chapter 7) and that this option is mediated by migratory status.

However, the state's limited vision regarding social inclusion is problematic for several reasons. First, because of the importance of (irregular) migrant labour for different sectors of the economy (Voorend *et al.*, 2013; Voorend and Robles, 2011; Sandoval, 2008; Morales and Castro, 2006), and because middle class women's labour insertion is dependent on migrants filling the gaps in chores and caretaking as informal labour (Martínez, Mora and Voorend, 2009). Second, it is problematic because of normative reasons justifying human rights based on personhood and not citizenship. Third, because its vision implies a limited scope of policy. That is, the state seems to understand integration as 'legality' and has (albeit not very successfully) focused on processes of regularization (Chapter 3) but fails to operationalize the law's ambiguously defined concept of 'integration'. The assumption that 'legality' leads to inclusion is only partly true (Chapters 7 and 8). That is, 'legality' is a necessary but not a sufficient condition for Nicaraguan migrants' social inclusion. Analysis of both quantitative and qualitative data on healthcare access confirm that regular migratory status is extremely important, but that even 'legal' migrants do not always have access to public healthcare and/or medicine.

This lack of access despite being 'legal' is rooted in processes of social exclusion and perceptions of migrants among those who directly influence the provision of social services. While it is almost impossible to scientifically establish causal relations between such perceptions and moves towards more restrictive policy without analysing the policy processes behind reform, it is equally improbable to deny that there is some relationship between the two. Among social service providers, social services are often understood as a welfare magnet for Nicaraguan migrants, 'illegal' migration

is considered undesirable and migrants demand for health services is generally questioned as illegitimate. Sometimes, narratives also manifest downright xenophobia. In the CCSS's complicated bureaucratic structure, the counter clerk, depending on that person's views on migration, can have strong influence over granting or denying a migrant access to health services.

In all, there is a mismatch between official laws, policies and *de facto* access to healthcare. That is, these macro issues are implemented, lived and negotiated at the micro, everyday level: social policy is partly made at the counters of clinics and hospitals. There appear to be issues in the training of medical and administrative staff at health centers that sometimes turn away migrants despite rights to receive service. This echoes inequalities along class, race, ethnicity, gender and other lines. As such, the healthcare system is often a mirror of larger inequalities and discriminatory practices in society, and serves as such in differentiating the immigrant and native population as well.

Finally, this research strongly questions welfare magnet arguments in Costa Rica. It shows that where migrants make use of social services, such instances are generally less than their share in the population and that most migrants make the appropriate contributions to such services. If anything, the data suggests an 'underrepresentation', and unlike what seems to be common perception, the bulk of the migrants seeking public health services contribute to such services. On the other hand, among the reasons to migrate to Costa Rica, healthcare and social services do not seem to feature as dominant (Chapter 7). Migrants are drawn (or pushed) by a potential better future. In the case of Nicaraguan migrants in Costa Rica, this better future is envisioned though labour opportunities, better education for their children, and generally not by the perspective of access to better social services in general, and health services in particular.

General Debates

The Costa Rican case engages with broader theoretical debates on the way migration and social policy interact in the South. Most importantly, the greater informality of labour markets, generally weaker welfare arrangements and poorer working conditions than in the Global North, arguably make for larger vulnerabilities for the migrant population. With less encompassing social policy that fails to cover the entire national population, the pressure to extend coverage to migrant populations is smaller, even if social policy is based on universal principles.

In this sense, the Costa Rican case underscores what Leerkes (2016) finds for The Netherlands: the idea that there is a growing differentiation in citizenship between

formally admitted migrants, and those considered non-members, or 'illegals'. However, this research questions whether the common claim in migration and citizenship scholarship, that migrants' rights increasingly resemble citizenship rights, is true for the South.

Within the *migration management* paradigm that guides much of today's migration policy, especially in Latin America, social policy is key as one of the principle mechanisms of migration control within a country. Even if countries acknowledge international human rights, reforming migration and social policy laws to be more inclusive to migrants' social rights, such discursive feats must be assessed against actual access to social policy. Indeed, inclusive language may be used to justify more stringent policy. This thesis therefore underscores the importance of the implementation gap to understanding migrants' chances for integration in the host society. Chances are conditioned on institutional and extra-legal processes of exclusion.

The findings also highlight the importance of distinguishing between 'illegality' as a conditioning factor for migrant inclusion (which it most definitely is), and 'illegality' being used as an active strategy to generate exclusions. Within the same *migration management* paradigm, 'illegality' is an effective policy tool to exclude migrants from welfare arrangements. As such, this research distances itself from research that talk down the importance of 'legality' for integration (Kalir, 2013; Agustín, 2003; Kyle and Siracusa, 2005).

Another interesting finding is how those actors directly involved in the creation of institutional mechanisms of exclusion generally interpret this exclusion as the result of voluntarist agency from the side of migrants. Put simply, migrants get excluded because they fail to meet the criteria for inclusion. The reciprocity in contribution to social security that is expected in return for health service access is generally considered positive by those involved with the provision of social services. The other side of the coin is that migrants, 'illegal' or without health insurance, have no legitimate claim to welfare arrangements and that they themselves are at fault for this exclusion.

At the same time, in the South, where institutional capacity to regulate standard service provision is weaker than in the North, counter clerks and health professionals can have significant power to determine whether a migrant receives a social service, or whether such a service meets the same quality standard as for nationals. That is, there is more fertile ground for deliberate mechanisms of identity-based discrimination. This is especially pressing in social policy regimes where universalism is eroding and access to quality social services is becoming more stratified.

Finally, the thesis shows how, in such a context, universalism can be stratified. In Costa Rica, universalism is considerably weaker for migrants than for nationals. Migrants' bargaining power is greatly reduced by mechanisms of exclusion, by the

unequal mediation of health service through markets, by punitive measures, and institutional obstructions and discrimination

This relative weakness of universalism for migrants relates especially to differences between nationals and migrants in the mechanisms for universalistic access to social services. This is problematic for migrant inclusion, because it means they do not access social policy on the same terms as nationals. It is also problematic for universalism. In Costa Rica, the erosion of universalism is exacerbated by increasing fragmentation, through increasing inequalities between different sections of society and ensuing parochial tendencies, also reflected by upper middle classes (slowly) pulling out of public social services and increasingly opting for private services.

The erosion of universalism is also exacerbated by fragmentations between nationals and migrants, the welfare magnet argument and the unwillingness (or inability) to include migrants in welfare arrangements. This leads to anti-immigrant political discourse, also quite common in European welfare states, which are often explicitly connected to social policy. In Costa Rica, migration is used as a scapegoat for the erosion of universalism and masks the underlying institutional and structural problems that weaken universal public social policy.

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APPENDICES

Appendix 1. *A Historical Overview of Healthcare Expansion*

In keeping with its generous social policies, Costa Rica has an extensive public healthcare system. Costa Rica has been hailed as a success story of "health without wealth" (Noy, 2012) and, despite its status as a developing country, has achieved high life expectancy and low levels of infant mortality (Sáenz *et al.* 2011: S158). This section provides a brief historic overview of Costa Rica's current healthcare architecture.

1940s: The Creation of the Caja Costarricense de Seguro Social

In 1941, during the administration of Dr. Rafael Angel Calderon Guardia, the *Caja Costarricense del Seguro Social* [Costa Rican Social Security Fund] (CCSS), also known as "La Caja", was created to administer an obligatory insurance. Its aim was to protect workers in situations of disease, and later on, in 1947, to provide support in conditions of maternity, invalidity, old age and death (Garnier Rímolo, 2006; Zamora Zamora, 2008). However, its creation was met with heavy opposition from medical staff, who were worried about the implications for their private practice —from employers who argued that the economic situation caused by the war in Europe would not allow them to take on additional expenses and even the workers themselves did not want to lower their wages to pay their part of the insurance (Jaramillo, 2004). On the first of November 1941, the *Ley Constitutiva de la Caja Costarricense de Seguro Social* [Constitutive Law of the Costa Rican Social Security Fund-No. 17] was approved (Miranda, 2003), establishing the legal framework for the institution's creation, and designating

the CCSS as the institution responsible for promoting and managing social insurance. Consequently, it was reformed in October 1943 to enact the institution's autonomy of self-government. Later, it was elevated to be included in the 1949 Constitution:

> Social security is established for the benefit of manual and intellectual workers, regulated by a system of compulsory contributions by the State, employers and workers, to protect them against the risks of illness, disability, maternity, old age, death and other contingencies determined by law (Art. 73; Costa Rican Constitution).

Initially, the CCSS's insurance coverage was low despite the "radical normative and conceptual progress" (Garnier Rímolo, 2006: 51) that the institution's creation implied. Indeed, insurance was limited to formal, salaried, and almost exclusively urban workers, and excluded their family members. Coverage was initially low, and started with 1,500 public servants employed at the time. Between 1944 and 1947, the compulsory health and maternity insurance spread across the country's Central Valley. By 1946, it covered nearly 50,000 workers (Miranda, 2003). By the end of that decade, insurance coverage had grown to 23% of the economically active population and 10% of the total population (Garnier Rímolo, 2006).

1950s and 60s: Slow but Gradual Expansion

In the 1950s, healthcare services had reached urban areas and the Central Valley's coffee producing zones among low income workers first (Martínez Franzoni & Sánchez Ancochea, 2013). More importantly, this decade saw the extension of insurance to dependent family members and to rural areas. In 1956, a mandatory family insurance was introduced for the wives or companions of workers, their children under 12 years and economically dependent parents. Between the late 1940s and 1960, the coverage of the salaried population grew from 23% to 38%. More importantly, because of this family insurance, social insurance coverage among the entire population grew from 8% to 46% in the same period (Miranda Gutierrez & Asis Beirute, 1989). By 1969, insured family members constituted 75% of all insured Costa Ricans (Jara Vargas, 2002).

Besides this important feat, expansion of the CCSS's insurance coverage was otherwise slow during the 1960s. Minor accomplishments included, in 1960, the extension of the Disability, Old Age and Death Insurance (IVM) to workers of commerce, special education, and professional consultancies, and municipal salaried workers. In 1962, public construction workers (especially aimed at railroad workers) were also included.

However, on the 12th of May 1961, Law N° 2738 amended the Constitution to determine a 10-year deadline to universalize social insurance. This amendment followed

concerned CCSS bureaucrats' requests to address the social security fund's financial shortages (Martínez Franzoni & Sánchez Ancochea, 2013)[i]. The proposed solution to increase private business' share in the social security funding, led to concerns among legislators about whether the new resources would actually be used for social insurance. The result was an unexpected, vaguely stated and "fairly innocuous" constitutional amendment (Martínez Franzoni & Sánchez Ancochea, 2013) that would prove to be the "most important reform in decades due to its long-term implications in driving the expansion of social protection".

1970s: Rapid Coverage Expansion

As part of the commitment to universalize health insurance over the next decade, the 1970s saw dramatic changes to the healthcare sector (Martínez Franzoni & Sánchez Ancochea, 2013; Zamora Zamora, 2008; Garnier Rímolo, 2006). In 1971, the First National Health Plan (1971-1974) was drafted and gradually implemented between 1971 and 1974. The plan determined, first, that a national health system be created; second, that there should be national coverage of primary health care programs by the Ministry of Health through rural and community programs, and; third, the universalization of medical attention for the entire population through the CCSS (Martínez Franzoni & Sánchez Ancochea, 2013). It was later extended through 1980.

Also in 1971, the CCSS's Constitutional Law (No. 4750) was amended to gradually extend social insurance coverage to all paid independent workers (firstly non-mandatory) and establish non-contributory programs to serve the poor. Finally, contribution ceilings of higher income employees were gradually eliminated to have higher earning groups contribute more to the CCSS (Ibid.).

In September 1973, Law No. 5349 transferred to the CCSS all hospitals of other institutions such as the Board of Social Protection, or the Banana companies' medical establishments, and hospitals administered by the Social Protection Boards (*Juntas de Protección Social*) that operated under the supervision Ministry of Health. Subsequently, in October of that same year, the General Health Law (No. 5395) was promulgated, declaring healthcare a common good of the public interest to be regulated under the tutelage of the state. A month later, the Organic Law of the Ministry of Health (No. 5413) was amended, which narrowed the Ministry of Health's focus to preventive and primary healthcare, while the CCSS would run all curative services. In the 1970s, over three quarters of hospitals and 81% of hospital beds were under the directive of the Ministry of Health. In 1985, just fifteen years later, the CCSS managed 85% of all hospitals, 95% of hospital beds, and 96% of hospital discharges

(Miranda, 1988). At the same time, while private hospital beds and discharges never represented a very significant share in this period (4% in 1970), the public sector's relative presence was fortified over the same period (1986: 2% of hospital beds and just under 3% of all discharges were private) (*idem*).

The year 1974 saw the creation of the Fund for Social Development and Family Allowance (FODESAF). Presently, FODESAF funds many family allowance and assistance programs, and hosts the Non-Contributive Pension regime, although this regime is administered by the CCSS. Importantly for healthcare, FODESAF channelled resources to primary health care programs under the Ministry of Health, including nutrition programs. At the same time, the Ministry of Health launched rural and community healthcare programs in the early 1970s, drawing on its experience with the malaria eradication programs, which covered immunization, complementary food, family planning, and latrine and sanitation programs. And as these programs rapidly reached more people both in urban and rural communities, more complex services were demanded from the CCSS, increasing the institution's primary care coverage as well.

1980s and 90s: Pressures to Reform

The 1980s and 1990s saw pressure to reform with Structural Adjustment Programs following Costa Rica's debt crisis of 1981. In the healthcare sector, this translated into a process of service integration between the CCSS and the Ministry of Health, with the aim to increase efficiency in the provision of healthcare services. Specifically, in 1981, a top executive decree (No. 13989) enacted an inter-institutional commission between the CCSS and the Ministry of Health. The aim of this commission was to revise and clarify the objectives and purposes of both institutions. Eventually, in 1993, this would result in the provision of all services related to health promotion, disease prevention, cure, and rehabilitation by the CCSS. In 1983, another decree (No. 14131) intensified internal restructuring, as the Ministry of Planning, Ministry of the Presidency, the Costa Rican Institute of Aqueducts and Sewers, the National Insurance Institute, and the University of Costa Rica were included in this process.

These commissions worked on reform proposals over this and the next decade. The main focus of these reforms was to improve the service delivery model, and the organization and financing of Costa Rica's healthcare system. This resulted in a proposal of reorganization of the health system, which according to Martínez Franzoni and Mesa-Lago (2003:45) included several important measures. First, the available basket of healthcare services was rearranged by level of care: healthcare centres, clinics, and hospitals. Each of these healthcare providers was to offer standardized services to the

public, focusing especially on increasing coverage on first level care. Second, the reform proposes a territorial allocation of healthcare services —that is, people access the different levels of health services depending on their domicile, except for the services only available at national hospitals.

Third, the financial, administrative, and service provision functions within the different levels of the health system were separated. This measure meant to emulate market mechanisms within the institution, avoiding responsibilities for the purchase and sale of services within one single department but instead creating a system in which different departments with the health system function as actors that relate to each other fulfilling different roles or functions. Fourth, the reform proposed mechanisms to determine resource allocation based on the needs of the population, going from a logic of "historic" resource allocation (based on previous budgets) to a prospective allocation (based on projections of future service needs). That is, central departments were to set up information systems to determine the healthcare needs of different segments of the population, and based on these demographic assessments consequently committed providers through "management goals" to the provision of certain healthcare services. In theory, compliance with determined goals could then be evaluated and compared between service providers by central departments.

Finally, while the CCSS remained the main institution responsible for financing health services, using resources from the national budget and tripartite social security contributions (Martínez Franzoni and Mesa-Lago, 2003), the resource allocation mechanism among healthcare providers did change, as did the promotion of mechanisms for private administrative contracting. While the provision of healthcare services to the CCSS was opened up to private competition, as was the second pillar complementary pension system, the health sector reforms in this period did not change the CCSS's monopoly on social security and tripartite financing of healthcare service provision, thereby safeguarding the institutionally determined principles of universalism, solidarity, and equity.

In 1988, toward the end of the century, a Hospital Decentralization Law (N° 7852) was passed, which gave larger degrees of freedom to public healthcare service providers. The Law granted several decentralized organs a juridical personality, thereby allowing, with varying degrees of freedom, more autonomy with regards to human resource and financial management, as well as possible administrative contracts with the private sector. This way, decentralized organs within a centralized public system of social security could subcontract auxiliary services to the private sector (Martínez Franzoni, 2001).

2000s: The Calm before the Storm?

The most important reform of the 2000s was the Worker Protection Law (*Ley de Protección al Trabajador*, No. 7983). This Law had important implications in terms of social security, making the CCSS responsible for raising employers' contributions related to labour capitalization funds and complementary pension funds. In terms of the provision of healthcare services, however, it did not propose radical change.

On May 30th, 2006, a series of small reforms to the Health Insurance Regulations were approved and implemented. The changes refer mainly to the terminology and definitions of the Regulations, which is important in terms of the eligibility criteria, but they do not alter the architecture of healthcare service provision. In all, besides the Worker Protection Law, there were no significant reforms during the first decade of the twenty-first century. However, the financial crisis the CCSS has been facing since 2008 due to economic slowdown has been discussed. In short, the financial crisis directly impacted the institution's income. More importantly, many years of mismanagement, recent cost and salary increases, combined with declining revenues and excessive growth of wage employment, the CCSS's financial situation deteriorated rapidly (Carrillo Lara *et al.*, 2011; PAHO, 2011). In 2011, things took a turn for the worse, when the CCSS announced a financial crisis that has called into question the institution's sustainability.

Notes

1 Martínez Franzoni and Sánchez Ancochea (2013) argue that two issues were particularly controversial with regards to the overall funding of the social insurance funds. First, increasing wage ceilings for higher wage level workers, and second, private sector fiscal contributions to social insurance. Especially, increasing business' share of business, and diminishing the government's share was considered important to solve the State's continual debt with the CCSS.

Appendix 2. *List of Interviewees and Interview Guide (in Spanish)*

List of Interviewees

DGME

1. Adrián Jiménez. Dirección de Planificación. Dirección General de Migración y Extranjería. Entrevista realizada el 1 de abril, 2013, 10:00 am.
2. Cinthia Mora Izaguirre. Dirección de Integración. Dirección General de Migración y Extranjería. Entrevista realizada el 3 abril 2013, 9:30 am.
3. Juan Carlos Siles. Ventanilla Preferencial. Plataforma de Servicios. Dirección General de Migración y Extranjería. Entrevista realizada el 10 mayo 2013, 3:00 pm.
4. Julio Aragón. Director de Integración. Dirección General de Migración y Extranjería. Entrevista realizada el 1 de abril, 2013, 10:00 am.
5. Luis Alonso Serrano. Jefe de Planificación Institucional. Dirección General de Migración y Extranjería. Entrevista realizada el 2 Mayo 2013, 9:00 am.
6. Ventanilla Empresarial. Plataforma de Servicios. Dirección General de Migración y Extranjería. Entrevista realizada el 10 mayo 2013, 3:00 pm.
7. Ventanilla Preferencial. Plataforma de Servicios. Dirección General de Migración y Extranjería. Entrevista realizada el 10 mayo 2013, 2:30 pm.
8. Adrián Jiménez. Dirección de Planificación. Dirección General de Migración y Extranjería. Entrevista realizada el 15 de octubre 2014, 10:00 am.
9. Kathia Rodriguez Araica. Directora Dirección General de Migración y Extranjería. Entrevista realizada el 23 de octubre 2014, 9:00 am.

CCSS

10. Dr. Douglas Montero. Director Médico. Hospital México, Caja Costarricense del Seguro Social. Entrevista realizada el 23 de Mayo 2013, 8:00 am.
11. Dr. José Luis Quiros. Patólogo Hospital Dr. Max Peralta, Caja Costarricense del Seguro Social. Entrevista realizada el 28 Agosto 2013, 5:00pm.
12. Dra. Ana Patricia Salas Chacón. Directora Institucional. Contraloría de Servicios. Caja Costarricense del Seguro Social. Entrevista realizada el 22 Abril 2013, 10:00 am.

13. Dra. Marta Jara. Área de Salud Heredia/Cubujuqui. Caja Costarricense del Seguro Social. Entrevista realizada el 25 Marzo 2012, 2:00 pm.
14. Dra. Yúrika Dorado Arias. Especialista Medicina Interna. Hospital Calderón Guardia. Caja Costarricense del Seguro Social. Entrevista realizada el 9 mayo 2014, 1:30 pm.
15. Eduardo Flores Castro. Jefe Área de Coberturas del Estado. Caja Costarricense del Seguro Social. Entrevista realizada el 24 abril 2013, 2:00 pm.
16. Funcionario. Dirección del Área de Inspección. Caja Costarricense del Seguro Social. Entrevista realizada el 29 abril 2013, 8:30 am.
17. Funcionario. Jefa de Área de Dirección de Inspección. Caja Costarricense del Seguro Social. Entrevista realizada el 29 abril 2013, 8:30 am.
18. Funcionario. Jefatura del Sub área de Investigación, Dirección de Inspección, Caja Costarricense del Seguro Social. Entrevista realizada el 29 abril 2013, 8:30 am.
19. Giselle Román. Enfermera. Área de Salud Heredia/Cubujuqui. Caja Costarricense del Seguro Social. Entrevista realizada el 19 de Marzo 2013, 2:30 pm.
20. Juan Pablo Barrantes. Trabajador Ventanilla. Área de Salud Heredia/Cubujuqui. Caja Costarricense del Seguro Social. Entrevista realizada el 25 Marzo 2013, 2:30 p.m.
21. Trabajadora de Ventanilla. Área de Salud Heredia/Cubujuqui. Caja Costarricense del Seguro Social. Entrevista realizada el 25 Marzo 2013, 2:30 pm.
22. Lic. Patricia Sánchez. Jefa de Área del Régimen No contributivo de Pensiones. Caja Costarricense del Seguro Social. Entrevista realizada el 6 de noviembre 2014, 8:30am.
23. Jaqueline Castillo Rivas. Dirreción Actuarial. Caja Costarricense del Seguro Social. Entrevista realizada el 18 de noviembre 2014, 9:00 am.
24. Dr. Miguel Perez. Médico General. Caja Costarricense del Seguro Social. Entrevista realizada 31 de enero, 2015.5:00 pm.
25. Validación de derechos. Área de salud de Goicoechea. Caja Costarricense del Seguro Social.
26. Lic. Adolfo Arias Coleman. Dirreción Pesiones Regimen Invalidez, Vejez y Muerte. Caja Costarricense del Seguro Social. Entrevista realizada el 18 de noviembre 2014, 9:00 am.

MEP & IMAS & FODESAF

27. Coordinadora Académica. Colegio Anastasio Alfaro. Ministerio de Educación Pública. Entrevista realizada el 24 de mayo 2013, 10:30 am.

28. Profesora de Estudios Sociales y Educación Física. Colegio Anastasio Alfaro. Ministerio de Educación Pública. Entrevista realizada el 24 de mayo 2013, 11:30 am.
29. Maybel Quirós. Educación Especial. Dirección de Desarrollo Curricular. Viceministerio Académico, Ministerio de Educación Pública. Entrevista realizada el 3 de abril 2013, 11:30 am.
30. Msc. Rosibel Herrera Arias. Coordinadora de Procesos Socioeducativos. IMAS-AVANCEMOS. Entrevista realizada el 29 de enero 2015, 8:30 am.
31. Licda. Andrea Jiménez Vargas. Trabajadora social. Unidad Local de Desarrollo Social AMON-ARDS Norest. IMAS. Entrevista realizada el 2 de febrero, 2015, 2:00 pm.
32. Amparo Pacheco. Directora. FODESAF. Entrevista realizada el 12 de marzo 2015, 11:00 am.
33. Juan Cancio Quesada. Subdirector. FODESAF. Entrevista realizada el 12 de marzo 2015, 11:00 am.

NGO/ACADEMICS

34. Karina Fonseca Vindas. Directora Servicio Jesuita para los Migrantes Costa Rica. Entrevista realizada el 5 de marzo 2013, 9:30 am.
35. Javier Hernández Lezama. Asociación Nicaragüense por la Democracia. Entrevista realizada el 11 de abril 2013, 4:00 pm.
36. Fidelina Mora Corrales. CARITAS-ANEP. Entrevista realizada el 12 de Abril 2013, 10:00 am.
37. Carlos Sandoval García. Varias comunicaciones personales entre enero 2012 y diciembre 2015.
38. Adolfo Rodriguez Herrera. Director Escuela de Economía, Universidad de Costa Rica. Entrevista realizada el 20 marzo 2015, 9:00 am.
39. Msc. Angelita Flores. Directora Secretaría Técnica de la REDCUDI. Entrevista realizada el 27 de Febrero 2015, 11:30 am.

OTHER

40. Ana Helena Chacón. Vicepresidenta de la República. Ministerio de la Presidencia República de Costa Rica. Entrevista realizada el 11 de febrero 2015, 5:30 pm.

Interview Guide

OBJETIVO DE LA PAUTA: Conocer las percepciones sobre los derechos sociales y el uso de los servicios sociales por parte de la población inmigrante nicaragüense, de personas activas en el sector público, la academia y ONGs. Presentar un acercamiento inicial y muy general, con el fin de obtener información sobre percepciones y su influencia en: *1.* La formulación y el diseño de políticas institucionales (funcionarios públicos de alto rango); *2.* La implementación de estas políticas (funcionarios públicos sin incidencia directa en el proceso de formulación y diseño, *ej.* doctores, funcionarios de "counters", maestros/as); *3.* Los problemas de implementación (sobre todo con académicos y ONGs).

1. Funcionarios Públicos de Alto Rango

- Sé que su institución atiende personas inmigrantes: ¿qué tipo de migrantes atienden? (¿de dónde? ¿estado migratorio? ¿condición socio-económica?)
- ¿Tienen algún proceso para obtener información sobre el estado migratorio? Si sí, ¿cómo saben el estado migratorio? ¿Es importante para su institución el estado migratorio de la persona para el acceso a servicios?
- ¿Cómo afectan las demandas de las poblaciones migrantes la prestación de servicios de su institución?

Crisis y Reacciones de Política

- ¿Cree usted que luego de la crisis económica de la CCSS, la atención a la población migrante se ha visto perjudicada? ¿Por qué? ¿Qué ha cambiado?
- ¿Considera usted que la demanda de servicios por parte de personas migrantes son causantes de las crisis institucionales, o de la seguridad social en particular? ¿Por qué?
- ¿Cómo afectan las demandas de las poblaciones migrantes la prestación de servicios de las instituciones sociales?
- La población inmigrante, ¿representa un reto/amenaza/oportunidad para la sostenibilidad de sus programas/de la institución? ¿Podría precisar de qué perfil o tipo de inmigrantes se habla en cada caso?
- En la formación de políticas de su institución, ¿se toma en cuenta el tema migratorio? ¿De qué manera? ¿Me podría dar ejemplos prácticos?
- ¿Existen programas especiales para migrantes? ¿Hay formas de asegurar que personas sin documentos no tengan acceso a sus programas?

- ¿Se incorporan las demandas, críticas y quejas de los migrantes en la formulación y/o reformulación de Políticas Sociales? ¿Se han adaptado programas pensando en limitar el acceso a la población inmigrante sin papeles? ¿Qué se ha hecho?
- ¿Qué mecanismos institucionales y políticos son utilizados para limitarles el acceso?
- ¿Conoce la Ley General de Migración y Extranjería (N° 8764)? ¿Qué implicaciones tiene/ha tenido para su trabajo? ¿En qué ha mejorado? ¿En qué ha empeorado?

Costa Rica como Imán del Bienestar

- ¿Considera usted que el recibir el servicio que usted/que esta institución ofrece, puede ser una causa suficientemente poderosa como para que personas decidan venir a vivir a Costa Rica? ¿Qué tipo de poblaciones de migrantes cree usted atrae, de dónde? ¿Y qué tipo de servicios sociales buscan principalmente?
- ¿Conoce usted anécdotas de personas inmigrantes que vinieron a Costa Rica para acceder los servicios sociales del país?
- ¿Considera usted que esta situación es positiva o negativa? ¿Por qué? (buscar que la respuesta sea lo más precisa posible)

2. Funcionarios de Nivel Operativo

- Sé que su institución atiende personas inmigrantes: ¿qué tipo de migrantes atienden? (¿de dónde? ¿estado migratorio? ¿condición socio-económica?)
- ¿Cuál es el peso de esta población inmigrante en el total de pacientes/estudiantes? Por ejemplo, de cada 10 personas que usted atiende, ¿cuántas estima no son costarricenses?
- Y más allá de los datos y de lo que dice la ley, ¿cuál es su percepción de la cantidad de personas migrantes que llegan al país?
- ¿Cuál es su percepción de "los tipos" de personas migrantes que llegan al país?
- ¿De la población migrante que usted atiende cuánta considera usted está en condición irregular? ¿Son muchas, pocas? De cada diez inmigrantes que atienden, ¿cuántos están en condición irregular? ¿Existe alguna documentación sobre la población irregular?
- ¿Tienen algún proceso para obtener información sobre el estado migratorio? Si sí, ¿cómo saben el estado migratorio? ¿Es importante para su institución el estado migratorio de la persona para el acceso a servicios?

- ¿Existen programas especiales para migrantes? ¿Hay formas de asegurar que personas sin documentos no tengan acceso a sus programas?

Percepción sobre Crisis de Prestación Social

- ¿Cómo afectan las demandas de las poblaciones migrantes la prestación de servicios de las instituciones sociales?
- ¿Considera usted que la población inmigrante forma parte de los problemas que enfrenta su institución? ¿De qué manera?
- ¿Considera usted que la demanda de servicios por parte de personas migrantes son causantes de las crisis institucionales, o de la seguridad social en particular? ¿Por qué?

Costa Rica como imán del bienestar

- ¿Considera usted que el recibir el servicio que usted /que esta institución ofrece, puede ser una causa suficientemente poderosa como para que personas decidan venir a vivir a Costa Rica? ¿Qué tipo de poblaciones de migrantes cree usted atrae, de dónde? ¿Y qué tipo de servicios sociales buscan principalmente?
- ¿Conoce usted anécdotas de personas inmigrantes que vinieron a Costa Rica para acceder los servicios sociales del país?
- ¿Considera usted que esta situación es positiva o negativa? ¿Por qué? (buscar que la respuesta sea lo más precisa posible)

3. Académicos y ONGs

- ¿Por qué accede esta población a los servicios que brindan las instituciones de servicios social? ¿Cuáles acceden y cuáles no? ¿Es porque tiene derechos? cuáles derechos?
- Las propias personas, ¿conocen sus derechos? ¿exigen sus derechos? ¿De qué formas?
- Costa Rica como imán del bienestar
- ¿Considera usted que el recibir el servicio que usted /que esta institución ofrece, puede ser una causa suficientemente poderosa como para que personas decidan venir a vivir a Costa Rica? ¿Qué tipo de poblaciones de migrantes cree usted atrae, de dónde? ¿Y qué tipo de servicios sociales buscan principalmente?
- ¿Conoce usted anécdotas de personas inmigrantes que vinieron a Costa Rica

para acceder los servicios sociales del país?
- ¿Considera usted que esta situación es positiva o negativa? ¿Por qué? (buscar que la respuesta sea lo más precisa posible)

Crisis y Reacción Política

- Ante múltiples crisis, ¿cuál ha sido la reacción de la política pública/social con respecto a la población inmigrante? ¿Es igual para todo tipo de inmigrante?
- ¿Cree usted que luego de la crisis económica/CCSS, la atención a la población migrante se ha visto perjudicada? ¿Por qué? ¿Qué ha cambiado?
- ¿Considera usted que la demanda de servicios por parte de personas migrantes son causantes de las crisis institucionales, o de la seguridad social en particular? ¿Por qué?
- ¿Se incorporan las demandas, críticas y quejas de los migrantes en la formulación y/o reformulación de Políticas Sociales? ¿Se han adaptado programas pensando en limitar el acceso a la población inmigrante sin papeles? ¿Qué se ha hecho?
- ¿Qué mecanismos institucionales y políticos son utilizados para limitarles el acceso?
- La Ley General de Migración y Extranjería (N°8764), ¿Qué implicaciones tiene/ha tenido para su trabajo? ¿En qué ha mejorado? ¿En qué ha empeorado?
- En general, ¿cómo la evalúa la política migratoria actual en este contexto de limitaciones a los derechos sociales o bien, el acceso a la política social?
- ¿Limita la Política Migratoria el acceso de la población migrante a servicios tales como educación, salud y vivienda? ¿Por qué?

Appendix 3. *Focus Group Discussion. Question Guide (In Spanish)*

Parte I: Proceso Migratorio y sus Razones

- ¿Por qué decidieron emigrar (salir) de su país?
- ¿Por qué decidió/decidieron venir a Costa Rica?
- ¿Qué ventajas y desventajas presenta Costa Rica como país para migrar?
- ¿Recibieron ayudas de parte del Estado (Gobierno), alguna organización, familiar, amigo o persona particular cuando llegaron?
- ¿Cómo fue su vida los primeros meses en Costa Rica?

Parte II: Estado Migratorio y Proceso de Documentación

- ¿Cómo están en este momento con el tema de los "documentos" (estado migratorio)?
- En el caso de estar "al día", ¿les parece fácil o difícil cumplir todos los requisitos y obtener los documentos? ¿Como fue el proceso de "estar legal"?

Parte III: Acceso a Servicios Sociales

- ¿Han recibido "ayudas" del Estado? ¿Dinero, becas (Avancemos o FONABE), subsidios, bono de la vivienda, servicios del CEN-CINAI, han participado del proyecto Manos a la Obra del IMAS, etc?
- ¿Esas "ayudas" les han servido para mejorar su situación?
- ¿Su nacionalidad o su condición migratorias les ha facilitado o dificultado acceder a los servicios sociales?
- ¿En sus trabajos están asegurados? ¿A ustedes y sus familiares los atienden en la CCSS?
- ¿Siente que el trato de los funcionarios de los hospitales, escuelas-colegios, y otras instituciones públicas son adecuados? ¿En algún momento se han sentido discriminados? ¿De qué formas?

Parte IV: Varias

- ¿Que ha sido lo más difícil de no vivir en Nicaragua?
- ¿Les gustaría en algún momento regresar a Nicaragua? ¿Por qué?
- ¿Qué temas en sus vidas mejoraron estando en Costa Rica?
  ¿Y cuáles empeoraron?

Appendix 4. *Survey Design and Implementation*

The Population and Control Group

As a first step, it was necessary to determine the size of the population with which I am dealing. The research is concerned with all Nicaraguan immigrants residing in Costa Rica, irrespective of their migratory status: Regular/legal or irregular/illegal. According to the Population Census of 2011, arguably the most reliable source of recent information available, the population of Nicaraguan born persons residing in Costa Rica is 287,766 Nicaraguans, representing 6.7 per cent of the total Costa Rican population.

Given the aim is to measure access to social policy amongst all Nicaraguan immigrants in Costa Rica, and consequently test the assumptions that, first, being an immigrant (versus a national), and second, legal status (regular versus irregular) are important determinants that stratify this access, as the sample design, the survey was aimed at all Nicaraguan born individuals residing in Costa Rica, as well as a control group of Costa Ricans with similar socio-economic characteristics. The Nicaraguan born sample constitutes immigrants with different migratory status. Some have obtained residency or citizenship, while others do not have a legal migratory status.

Ideally, to enable useful comparisons, the control group of non-immigrant Costa Rican born nationals should be similar to the immigrant group (treatment group, as it were) in terms of observed and unobserved traits, except for their migratory status. This is indeed a difficult condition to satisfy but to try and do this, it was decided to use a control group of Costa Rican-born individuals with similar characteristics, by interviewing Costa Rican born individuals living in the same neighbourhoods as the target population. Given the sampling was based on relatively small areas that confined around 100 houses, as will be explained in more detail, this strategy in practice ensured that Nicaraguan born and Costa Rican born populations shared relatively similar socio-economic features.

On Power, Confidence Levels and Sample Size

As is standard for most social-science applications, the survey design was based on a 95% confidence level, identifying a risk of 1 in 20 that actual error is larger than the margin of error. In other words, the probability of Type I errors (α) is set to be 5%.

Having chosen a 95% confidence level, the power of the test describes the probability that the randomly chosen sample will detect a difference of the specified type

when the procedure is applied, if the specified difference does indeed exist. In other words, the power of the test describes the probability of committing a Type II error (β), which means accepting the null hypothesis when it is in fact false. The power of test, then, is 1-β, or in words correctly rejecting the null hypothesis when it is false.

To estimate the power of a test, it is necessary to know by how much the independent variable of interest affects the dependent variable. In this case, we would like to know the effect of migratory status on access to social policy, we have no information for and hence is impossible to determine beforehand. Therefore, a conservatively small effect size (Cohen's *d*) of *d*=0.2 will be assumed.

Now, these inputs allow us to calculate the sample size required for the survey. The table below shows the sample size required for a Two-Sample T-test to achieve a given level of Power of Cohen's three effect sizes, of small *d* (0.2), medium *d* (0.5) and large *d* (0.8) and α of 0.05, and aiming for a power of the test of 80%.

Table A4-1. *Sample Size Required for a Two-Sample T-test to Achieve a Given Level of Power of a Given Effect Size and α of 0.05*

	Cohen's Effect Size		
Power	*0.2*	*0.5*	*0.8*
0.25	84	14	6
0.50	193	32	13
0.60	246	40	16
0.70	310	50	20
0.80	393	64	26
0.90	526	85	34
0.95	651	105	42
0.99	920	148	58

Source: Cohen (1977).

Assuming a small effect size, for a α of 0.05 and to achieve a level of power of 0.80, the sample size for the treatment group of Nicaraguan immigrants should be n=393, with control group of 393 Costa Rican born nationals. To be sure, the survey aimed at gathering information for a sample of 400 Nicaraguan immigrants and 400 nationals. Given that the response rate was impossible to determine beforehand, the aim was to fill this quota of 400 and 400 interviews determined above. That is, the fieldwork continued as long as necessary to conclude the desired sample size. In the end, data was gathered for 394 migrants and 401 nationals.

Operational Strategy and Sampling Technique

As part of the operational strategy, INEC (2011) through its *Censo de Población* 2011 provides public information on the number of people residing in each of the 472 Costa Rican districts, and this can be disaggregated by the country in which those people were born. The district level is the most disaggregated information that is available to the general public.

The populations of each district were listed by country of birth, ordered following INEC's classification based on the province they belong to. Consequently, a running cumulative of the Nicaraguan born population in Costa Rica was calculated, the logic of which is shown in Table A4-2.

Table A4-2. *Total Population in Costa Rica's Districts, by Country of Birth.*

			Country of Birth			
No.	***Province***	***District***	*Costa Rica*	*Nicaragua*	*Other*	***Running Cumulative Nicaraguan Born Population***
1	San José	Carmen	2,039	287	376	287
2	San José	Merced	8,854	2,624	779	2,911
3	San José	Hospital	15,368	3,346	556	6,257
.	.	.	.	.	.	.
.	.	.	.	.	.	.
.	.	.	.	.	.	.
470	Limón	Pocora	5,852	545	35	286,366
471	Limón	Río Jim.	8,016	658	68	287,024
472	Limón	Duacarí	5,268	742	49	287,766

Source: Own elaboration based on INEC (2011).

This running cumulative was necessary for the sampling technique chosen to identify where in the country the survey had to be taken: Probability Proportional to Size Sampling Technique (PPS), in which the probability of selecting a sampling unit (in this case a district) is proportional to the size of its population (in this case Nicaraguan born population). This technique gives a probability sample, *i.e.* random and representative, and was considered useful because the sampling units (districts) vary considerably in size. In this case PPS sampling ensures that those immigrants in larger districts have the same probability of getting into the sample as those in smaller districts, and vice versa.

Consequently, the total Nicaraguan born population of 287,766 was divided by the number of sites that were to be visited for the survey, to determine the Sampling Interval (*SI*). While several different scenarios were considered, the final number of 20 sites for the survey was determined based on financial and operative considerations.

In other words, it was the highest possible number of visiting sites considering the limited budget, and the implications in terms of travelling (costs) of a higher number of sites. The *SI* in this case was 14,388. To start the PPS, a number between 1 and the *SI* was randomly chosen as the Random Start (*RS*). This number was 8,954. Then, the following series were calculated:

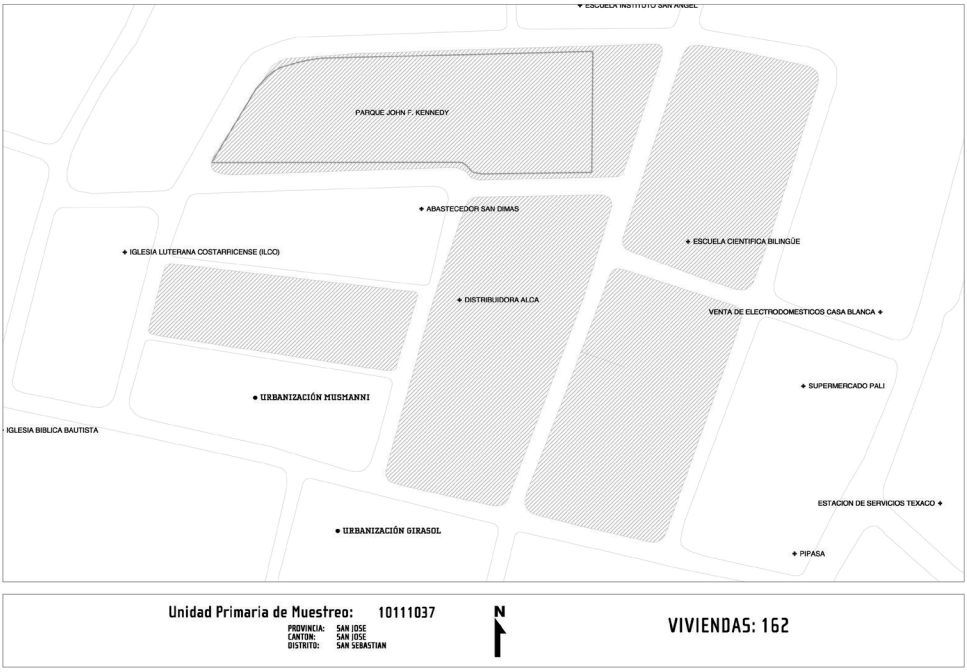
$$RS;\ RS + SI;\ RS + 2SI;\ RS + 3SI + \ldots;\ RS + 18SI;\ RS + 19SI.$$

Each of these 20 numbers corresponds to a site on the list of districts. The districts selected are those for which the column "Running Cumulative Nicaraguan Born Population" contains the numbers in the series that were calculated. Having selected the 20 districts, the next step was to approach the INEC for support. Districts vary a lot in terms of population size, some being host to over 20,000 people, and in terms of extension. The INEC manages a segment system that disaggregates further these districts, into what are called "*Unidades Primarias de Muestreo*" [Primary Sampling Units], or UPMs. While INEC does not make public this information because of ethical concerns, it does provide assistance with sampling.

Thus, the INEC was asked to provide two samples, of 50 and 100 UPMs, within the preselected districts that encompassed a total of 955 UPMs. As a sampling technique for the selection of the UPMs, the same PPS technique was used, with the crucial difference that the running cumulative was not based on total Nicaraguan born population, but on the basis of total number of households in the UPM. This was due to a technical difference between INEC's UPM it uses for the classification of data and sampling for general public, and the "*Unidades Geoestadísticas Mínimas*" [Minimal Geostatistical Units] (UGM) used for the collection of census data. In personal communications with INEC staff, I was explained that these are very similar but not exactly the same, and that their system does not document the population by country of birth. Providing this information would have implied a lot of work by INEC, which they were willing to do only for a much higher fee. This proved to be a significant methodological hurdle. The problem was that for some UPMs, there was simply not enough Nicaraguan population to be interviewed (which is a probability in PPS sampling, in any case), in which case an alternative strategy had to be deployed, as discussed below. However, and importantly, the modification applied in the field aimed to avoid alterations to the randomness of sampling. Luckily, given the pre-selection of districts with higher probability to have larger Nicaraguan born population, combined with the fact that more densely populated UPMs within these districts had higher probability of being selected; in most cases it proved relatively easy to find the targeted population within the UPM.

In all, given the limited resources, 50 UPMs were chosen given that these were already quite far apart in some cases, and since the whole country was to be covered, the data collection would imply several trips outside the Grand Metropolitan Area. In each of these 50 UPMs, a total of 8 Nicaraguan born and 8 Costa Rican born persons had to be interviewed, to make a total of 800 surveys. INEC consequently provided the necessary information on the selected UPMs, their location and most importantly a map of each UPM. These maps depicted geographical information, like streets and rivers, and location points easily identified, like churches, hotels, football fields. They did not, however, depict houses.

Figure A4-1. *Example of UPM Map, as Provided by INEC.*

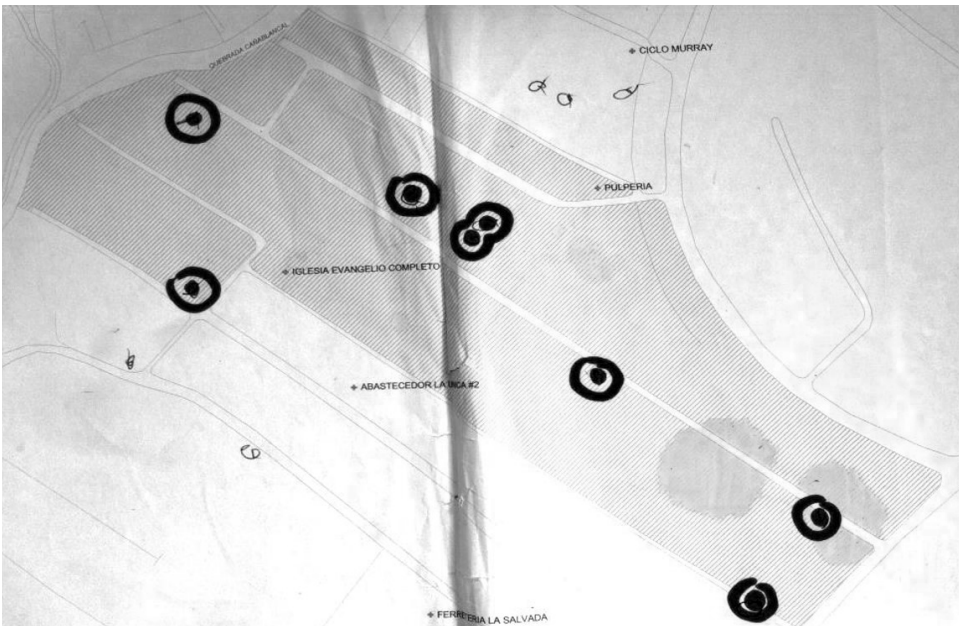


Source: INEC (2013).

This meant that for the actual selection of households/houses, a more rudimentary but random technique had to be used. For each map, one of the interviewers was blindfolded and while another interviewer continuously pivoted the map from left to right, he or she made dots on the colored part of the map, until exactly 8 dots appeared on the area that depicted the UPM. Finally, in the field, houses closest to the dot were approached until at least one immigrant and one national residing in one of the houses

were found willing to participate in the survey. The maps would look something like the one in Figure A4-2.

Figure A4-2. *Selecting the Locations for Surveying within the UPM.*



Source: Own photo from UPM Map provided by INEC (2013).

Survey Execution and Operational Hiccups

As is common in survey fieldwork, there were several situations that needed attention. Most of these situations were a result of the PPS methodology used as a sampling strategy, which gives a higher probability to districts with high immigrant population to be sampled, but it does not provide a guarantee. Indeed, it is possible that low immigrant density districts are selected. Second, within the districts selected using PPS, the INEC used the same sampling strategy to select UPMs. However, because of the technical difference between UPMs and UGMs previously explained, within the selected UPMs, high density areas were selected, but not necessarily with immigrant population.

Now, this increases the (with PPS already existent) probability of non-immigrant UPMs to make it to the final sample. Indeed, in practice this provided some challenges, given that in some of the UPMs selected it proved difficult to find immigrant

populations. For these UPMs, it was necessary to make adjustments to the methodology. In most cases, these adjustments were minor and implied filling the 8 survey quota per UPM, with one or two surveys outside the UPM. In practice, this meant crossing the street and finding an immigrant home in a neighboring UPM. In a few cases, the adjustment entailed more work. Some UPMs sampled proved to be gated communities (2), or simply neighborhoods with no (visible) immigrant population (2). In two other UPMs, the safety of the interviewers was compromised and it was decided to discontinue the survey there. In these cases, the UPM was replaced with the closest other (in all but one adjacent) UPM where there was immigrant population present. This entailed asking around, or simply knocking doors.

Table A4-3. *UPMs and Methodology Adjustments*

Methodology	*Number of UPMs*
According to Plan	32
Small Adjustment	12
Replacement	6

Source: Own elaboration.

In all, the randomness of the sample is not believed to have been affected in any way. The initial selection was as arbitrary as the consequent adaptation, which in all but one case implied the selection of the adjacent UPM where immigrant population was indeed found. Indeed, every Nicaraguan-born person residing in Costa Rica would have the same probability being sampled.

Appendix 5. *Survey Questionnaire (in Spanish)*

ENCUESTA MISOC-CR 2013/2014:
Migración y política social en Costa Rica
MSc. Koen Voorend · Estudiante doctoral ISS-EUR

PARA EL ENCUESTADOR, LLENAR LO SIGUIENTE:

A.	Encuestador		B.	Número de encuesta	
C.	UPM - Código		D.	Municipio	
E.	Lugar de entrevista		F.	Fecha entrevista	

ENCUESTA SOBRE EL ACCESO DE LA POBLACIÓN A LA POLÍTICA SOCIAL COSTARRICENSE

Buen día. Soy investigador en un equipo de la Universidad Erasmus de Rotterdam en Holanda. Estamos realizando esta encuesta a fin de conocer el acceso que tienen las personas viviendo en Costa Rica a los servicios sociales del Estado - es decir, relacionados con educación, salud, vivienda etc. La entrevista dura alrededor de 30 minutos. Todos los datos que usted nos proporcione serán confidenciales, anónimos y no serán usados fuera de esta investigación. Puede responder libremente a esta encuesta. Si hay preguntas que no quiere responder, no hay problema, sólo hágamelo saber. No hay respuestas buenas, ni malas en esta encuesta, así que siéntase en libertad de responder de forma sincera. Le agradezco de antemano su buena voluntad y su participación.

Sección 1- Información personal (* Observación del encuestador)					
1*	***Sexo de la persona entrevistada*** *(1=M; 2=F)*		**5**	***Estado conyugal de la persona entrevistada***	
2	***Edad de la persona entrevistada en años***			1. Casado/a	
3	***¿En qué país nació?*** *(anotar código)*			2. Soltero/a	
	1 = CR; 2 = NIC; 3 = Otro. Anote			3. Unión libre	
4	***¿Qué nacionalidad tiene?*** *(anotar código)*			4. Divorciado/a	
	1 = CR; 2 = NIC; 3 = Ambos, 4= Otro, anotar			5. Viudo/viuda	
Sección 2- Información sobre las relaciones familiares					
6	***¿Es usted jefe/a del hogar en que vive?*** *(1=si; 0=no)*		**11**	***¿Cuántas de estas personas viven de manera permanente con usted en Costa Rica (sin incluirse)?***	
7	***¿Tiene hijos/as?*** *(1=si; 0=no)*				
8	***¿Cuántos hijos/as tiene?***	♀ ♂	**12**	***¿Cuántas de estas personas viven en otro lugar en Costa Rica?***	
9	***¿Cuántos hijos menores de 6 años?***	♀ ♂	**13**	***¿Cuántas de estas personas viven en Nicaragua?***	
			14	***¿Cuántas personas aportan al ingreso familiar?***	
10	***¿Cuántos miembros de su hogar/familia comparten el mismo presupuesto, incluyendo personas que viven en otros países?***		**15**	***¿Cuántas personas dependen mayoritariamente del ingreso del jefe del hogar/de la persona que más aporta al ingreso?***	

16. Sobre el/la jefe/a de hogar:

A	B	C	D	E	F		G	H	I	J
Estado civil jefe [Códigos abajo]	**Ocupación principal** (anotar)	**Nacido en…** CR= 1 NIC=2 OTRO= 3 (especificar)	**Sexo** M=1 F=2	**Edad en años cumplidos**	**Alfabetismo** Lee Si=1 No=0	Escribe Si=1 No=0	**Años de estudio***	**Nivel educativo más alto completado** [Códigos abajo]	**País en que hizo estudios** CR = 1 NIC = 2 Ambos = 3 Otro = 4	**Tipo de Educación** Pública = 1 Privada = 2

17. Sobre los miembros del hogar que viven en Costa Rica (MARCAR CON CÍRCULO LA PERSONA ENTREVISTADA):

No.	A	B	C	D	E		G	H	I	J	K
No. de miembros hogar +	**Relación con jefe de familia** [Códigos abajo]	**Nacido en…** CR= 1 NIC=2 OTRO=3 (especificar)	**Sexo** M = 1 F = 2	**Edad en años cumplidos**	**Alfabetismo** Lee Si=1 No=0	Escribe Si=1 No=0	**Años de estudio***	**Nivel educativo más alto completado** [Códigos abajo]	**País en que hizo estudios** CR =1 NIC =2 Ambos =3 Otro=4	**Tipo de Educación** Pública = 1 Privada = 2 Semi =3	**Ocupación principal** (anotar)
1											
2											
3											
4											
5											
6											

Códigos

1.A. Estado civil del Jefe de hogar	2.A. Relación con jefe de familia		H. Nivel escolaridad (más alto)		
1. Casado(a) / acompañado(a), con el (la) cónyuge siempre presente en el hogar 2. Casado(a) / acompañado(a), con el (la) cónyuge emigrante (es decir, el (la) cónyuge tiene todavía vínculos económicos con el jefe de familia) 3. Soltero(a) / viudo(a) / divorciado(a) / separado(a) . Vive solo. 4. Soltero(a) / viudo(a) / divorciado(a) / separado(a) . Vive juntado.	1. Cónyuge 2. Padre/Madre 3. Hijo/a 4. Hermano/a	5. Sobrino/a 6. Cuñado/a 7. Tio/a 8. Otro, especifique	0. Ninguno 1. Primaria incompleta 2. Primaria completa 3. Secundaria incompleta 4. Secundaria completa 5. Universitario incompleto	6. Universitario completo 7. Diplomado incompleto 8. Diplomado completo 9. Técnico incompleto 10. Técnico completo	*Sumar años de primaria (6), secundaria (5), técnico básico, medio y superior y educación universitaria. Cursos no se incluyen. + Códigos para el spreadsheet en Excel: 17-1A, 17-1B… y 17-2A, 17-2B…etc.

Sección 3 - Sobre el acceso a la política social en Costa Rica

18. ¿Durante este año, algún miembro del hogar ha recibido ayuda del IMAS: en dinero, otro tipo de ayuda o participó en algún programa, capacitaciones u otro? (1) sí (0) no

Si, ¿cuál es?	Nombre programa	Monto en ₡/$ (especificar)	Periodicidad (1:-año, 2:mes,3: irregular, 4:otro)	¿Cuántas veces recibió este monto?
	1. Avancemos			
	2.			
	3.			
	4.			
	5.			

18b. En algún momento antes de este año, algún miembro del hogar ha recibido ayuda del IMAS: en dinero, otro tipo de ayuda o participó en algún programa, capacitaciones u otro? (1) sí (0) no

Si, ¿cuál es?	Nombre programa	Monto en ₡/$ (especificar)	Periodicidad (1:-año, 2:mes,3: irregular, 4:otro)	¿Cuántas veces recibió este monto?
	1. Avancemos			
	2.			
	3.			
	4.			
	5.			

19. Durante este año, ¿alguna persona de este hogar recibió el bono de vivienda? (1) sí (0) no

Si, ¿cuál es?	Nombre bono	Monto en ₡/$ (especificar)	Periodicidad (1:-año, 2:mes,3: irregular, 4:otro)	¿Cuántas veces recibió este monto?
	1.			
	2.			
	3.			

19b. En algún momento antes de este año, ¿alguna persona de este hogar recibió el bono de vivienda? (1) sí (0) no

Si, ¿cuál es?	Nombre bono	Monto en ₡/$ (especificar)	Periodicidad (1:-año, 2:mes,3: irregular, 4:otro)	¿Cuántas veces recibió este monto?
	1.			
	2.			
	3.			

20. ¿Durante este año algún miembro del hogar ha recibido servicios del CEN-CINAI? (1) sí (0) no

Si, ¿cuáles?	
	1. Atención en un centro infantil durante todo el día
	2. Comidas servidas
	3. Paquete alimentario
	4. Leche
	5. Otro
	88. No sabe

20b. ¿En algún momento antes de este año, algún miembro del hogar ha recibido servicios del CEN-CINAI? (1) sí (0) no

Si, ¿cuáles?	
	1. Atención en un centro infantil durante todo el día
	2. Comidas servidas
	3. Paquete alimentario
	4. Leche
	5. Otro
	88. No sabe

21. ¿Cuenta en Costa Rica con seguro social? (1) sí (0) no

Si, ¿cuál?	
	1. Asalariado
	2. Mediante convenio (asociaciones, sindicatos cooperativas, etc.)
	3. Cuenta propia o Voluntario
	4. Por el Estado (incluye al familiar de asegurado por el Estado)
	5. Familiar de asegurado directo *(asalariado, mediante convenio, voluntario)*
	6. Pensionado del régimen no contributivo monto básico
	7. Pensionado del régimen no contributivo de Gracia o Guerra
	8. Pensionado del régimen de IVM de la CCSS
	9. Pensionado del régimen: Magisterio, Poder Judicial, Hacienda, otro
	10. Familiar de pensionado
	11. Otras formas (seg. de estudiante, de refugiado, otros)
	12. Seguro privado o del extranjero
	88. No sabe

22. ¿Cotiza para algún Régimen de Pensiones? (1) sí (0) no

Si, ¿cuál?	
	1. Régimen de IVM de la CCSS
	2. Magisterio y régimen de IVM de la CCSS
	3. Sólo Magisterio
	4. Otro régimen (Poder Judicial, Hacienda, etc)
	5. Otro privado,
	88. No sabe

23. Sus hijos menores a 6 años, van donde algún centro de cuido/de educación o alguna persona que los cuida si usted está fuera/trabajando? (1) sí (0) no

Si, ¿cuál?	
	1. Los cuidan en la red de cuidos/programa del Estado
	2. Van a un kinder / prematernal que paga
	3. Contrata una muchacha que los cuida (pagado)
	4. Algún familiar los cuida, *especifique*
	5. Alguna persona no familiar los cuida (no pagado)
	6. Otro, *especifique*

23a. Cuando sus hijos tenían menos de 6 años, iban donde algún centro de cuido/de educación o alguna persona que los cuida si usted está fuera/trabajando? (1) sí (0) no

Si, ¿cuál?	
	1. Los cuidan en la red de cuidos/programa del Estado
	2. Van a un kinder / prematernal que paga
	3. Contrata una muchacha que los cuida (pagado)
	4. Algún familiar los cuida, *especifique*
	5. Alguna persona no familiar los cuida (no pagado)
	6. Otro, *especifique*

24. ¿Sus hijos, asisten a una escuela o un colegio público en Costa Rica? (1) sí (0) no

24a. Cuando sus hijos estaban en edad, ¿asistían a una escuela o un colegio público en Costa Rica? (1) sí (0) no

25. Alguno de sus hijos, ¿cuenta con una beca otra que Avancemos? (1) sí (0) no

Si, ¿cuál?	Nombre programa	Monto en ₡/$ (especificar)	Periodicidad (1:-año, 2:mes,3: irregular, 4:otro	¿Cuántas veces recibió este monto?

25a. Alguno de sus hijos, ¿en algún momento contaba con una beca otra que Avancemos? (1) sí (0) no

Si, ¿cuál?	Nombre programa	Monto en ₡/$ (especificar)	Periodicidad (1:-año, 2:mes,3: irregular, 4:otro	¿Cuántas veces recibió este monto?

26. Si usted se siente mal/enfermo(a), y necesita ver un doctor, ¿usted va a la CCSS/EBAIS? *(LEER RESPUESTAS)* (1) sí (0) no

Si no, ¿por qué no?	
	1. No tiene derecho a atención médica de la CCSS/EBAIS por su estado migratorio
	2. Le cobran por los servicios de la CCSS/EBAIS
	3. No le atienden en la CCSS/EBAIS
	Especifique por qué
	4. Prefiere una clínica/doctor privado
	Especifique por qué
	5. El horario no le conviene
	6. Solo si fuera una emergencia de vida
	7. Otra razón, *especifique*

27. Si sus hijos (menores de 18) están enfermos, y necesitan ver a un doctor, ¿usted los lleva a un EBAIS/Hospital? *(LEER RESP.)* (1) sí (0) no

Si no, ¿por qué?	
	1. No tienen derecho a atención médica de la CCSS/EBAIS por el estado migratorio de sus hijos
	2. No tienen derecho a atención médica de la CCSS/EBAIS por el estado migratorio suyo
	3. No los atienden en la CCSS/EBAIS, *Especifique por qué*
	4. Le cobran por los servicios de la CCSS/EBAIS
	5. Prefiere una clínica/doctor privado. *Especifique por qué*
	8. El horario no le conviene
	6. Solo si fuera una emergencia de vida
	7. Otra razón, especifique

28a. Si necesita alguna medicina para usted, ¿normalmente dónde la consigue? *(LEER RESP.)*

1. La busca en la CCSS o un EBAIS, sin que me cobren
2. La busca en la CCSS o en un EBAIS, pero me cobran
3. La compra en una farmacia
4. Conoce una persona que se la consigue. Usted le paga.
5. La consigue en Nicaragua, se la mandan
6. Otra forma, especifique
0. No puede conseguir medicinas

28b. ***Si necesita alguna medicina para sus hijos (menores de 18 años), ¿normalmente dónde la consigue?*** *(LEER RESP.)*	
1. La busca en la CCSS o un EBAIS, sin que me cobren	
2. La busca en la CCSS o en un EBAIS, pero me cobran	
3. La compra en una farmacia	
4. Conoce una persona que se la consigue. Usted le paga.	
5. La consigue en Nicaragua, se la mandan	
6. Otra forma, especifique_____	
0. No puede conseguir medicinas	

29a. Si alguien en <u>su familia en Costa Rica que no tiene seguro</u> necesitara una operación, ¿qué haría? *(LEER RESP.)*	
1. Pide cita en un hospital en la CCSS o un EBAIS	
2. Pide cita con un doctor privado en Costa Rica	
3. Regresa a Nicaragua. Prefiere la atención médica en Nicaragua.	

29b. Si <u>sus hijos o alguien en su familia en Costa Rica que sí seguro</u> necesitara una operación, ¿qué haría? *(LEER RESP.)*	
1. Pide cita en un hospital en la CCSS o un EBAIS	
2. Pide cita con un doctor privado en Costa Rica	
3. Regresa a Nicaragua. Prefiere la atención médica en Nicaragua	

29c. Si alguien en <u>su familia viviendo en otro país</u> necesitara una operación, qué haría? *(<u>LEER RESP.</u>)*	
1. Busca atención médica del Estado en Nicaragua	
2. Busca atención médica privada en Nicaragua	
3. Busca atención médica en Costa Rica, en la CCSS	
4. Busca atención médica privada en Costa Rica	
5. Busca atención médica en otro país, especifique	

3a - Sobre el gasto en citas médicas, medicina y educación

	(CR ₡)	(US$)
30. El mes pasado, ¿cuánto dinero gastó en citas médicas para usted y su familia?		
30a. La última vez que usted tenía una cita médica, ¿cuánto dinero gastó en esta cita?		
30b. La última vez que sus hijos tenían una cita médica, ¿cuánto dinero gastó en esta cita?		
31. El mes pasado, ¿cuánto dinero gastó en medicinas para usted y su familia?		
31a. La última vez que tenía que conseguir medicinas para usted, ¿cuánto dinero gastó en estas medicinas?		
31b. La última vez que tenía que conseguir medicinas para sus hijos, ¿cuánto dinero gastó en estas medicinas?		
32. El mes pasado ¿cuánto dinero gastó en su educación y/o la de tu familia?		

3b. Sobre la cercanía de los servicios sociales

33. La escuela más cercana de usted se encuentra a una distancia de…		***34. El EBAIS más cercano de usted se encuentra a una distancia de…***		***35. El hospital (CCSS) más cercano de usted se encuentra a una distancia de…***		***36. El hospital o clínica privada más cercano de usted se encuentra a una distancia de…***	
1. Menos de 1 km		1. Menos de 1 km		1. Menos de 1 km		1. Menos de 1 km	
2. Entre 1 y 2 km		2. Entre 1 y 2 km		2. Entre 1 y 2 km		2. Entre 1 y 2 km	
3. Entre 2 y 5 km		3. Entre 2 y 5 km		3. Entre 2 y 5 km		3. Entre 2 y 5 km	
4. Entre 5 y 10 km		4. Entre 5 y 10 km		4. Entre 5 y 10 km		4. Entre 5 y 10 km	
5. Más de 10 km		5. Más de 10 km		5. Más de 10 km		5. Más de 10 km	

3b – Sobre la percepción de la calidad de los servicios sociales y de la dificultad del acceso

37. La calidad de la escuela en Costa Rica, usted la calificaría como:	
1. Muy buena	
2. Buena	
3. Regular	
4. Mala	
5. Muy mala	
88. NS/NR	

38. En comparación con su país, la calidad de la escuela en Costa Rica es:	
1. Mucho mejor	
2. Mejor	
3. Igual	
4. Peor	
5. Mucho peor	
88. NS/NR	

39. La calidad de los servicios médicos en Costa Rica, usted la calificaría como:	
1. Muy buena	
2. Buena	
3. Regular	
4. Mala	
5. Muy mala	
88. NS/NR	

40. En comparación con su país de origen, la calidad de los servicios médicos en Costa Rica es:	
1. Mucho mejor	
2. Mejor	
3. Igual	
4. Peor	
5. Mucho peor	
88. NS/NR	

41a. Cuando usted quería matricular a sus hijos/hijas en la escuela en Costa Rica, fue posible?	(1) sí	(0) no
41b. Si no, ¿Por qué cree usted que no se pudo?		
1. No había escuela cerca		
2. No sabía que en Costa Rica se ofrecía este servicio para sus hijos		
3. Le negaron la matrícula porque usted/sus hijos no tenían los papeles al día		
4. Le negaron la matrícula porque no es costarricense		
5. Otra razón, especifique_____		
88. No aplica/NS/NR		

42a. Cuando usted necesitaba atención médica de la CCSS para usted en Costa Rica, fue posible?	(1) sí	(0) no
42b. Si no, ¿Por qué cree usted que no se pudo?		
1. No había clínica cerca		
2. No sabía que podía buscar la atención en la CCSS		
3. Le negaron la atención porque usted no tenía sus papeles al día		
4. Le negaron la atención porque no es costarricense		
5. Otra razón, especifique_____		

43a. En comparación con las personas costarricenses que usted conoce, acceder a los servicios de educación, salud y vivienda, para usted es…	
1. Más fácil	
2. Lo mismo	
3. Más difícil	
43b. ¿Por qué considera esto? (anotar razones)	

Sección 4 – Sobre el proceso migratorio

4a – Sobre el cuándo

44. ¿En qué año vino por primera vez a Costa Rica?		(anotar año)	
45a. ¿Ha vivido en Costa Rica todo este período?		(1) sí	(0) no
45b. Si no:	Desde que vino a Costa Rica, ¿Ha vuelto a vivir en Nicaragua un período?	(1) sí	(0) no
	Desde que vino a Costa Rica la primera vez, ¿Ha vivido en otro país que no sea Nicaragua?	(1) sí	(0) no
46. ¿Cuándo ingresó por última vez a Costa Rica?		mes	año
47. ¿Cuántas veces al año regresa a Nicaragua?			
48. En promedio, ¿cuántos días se queda en Nicaragua cada vez que va?			

49. ¿Por qué motivo regresó la última vez a Nicaragua?	
1. Visitar a familia	
2. Vivir un tiempo	
3. Para conseguir documentos	
4. Otro	

50. ¿De cuánto tiempo ha sido el período más largo que vivió en Costa Rica sin interrupciones?	(años)	(meses)

51. En este momento, usted se encuentra en el país…	
1. De forma temporal (menos de 6 meses)	
2. De forma permanente	
3. En períodos de trabajo (vuelve a Nic días/períodos no laborales)	
4. Sólo por esta cosecha / un trabajo específico	
5. Otra forma, especifique	

4b –Sobre la situación antes de migrar

52. Antes de venir a Costa Rica, ¿en qué departamento vivía? ***(Anotar)***

53. En Nicaragua:	***0=no***	***1= sí***	**53. cont…**	***0=no***	***1= sí***
1. ¿Tenía trabajo remunerado?			5. ¿Tenía casa propia?		
2. ¿Cotizaba para un seguro social?			6. ¿Vivía con sus padres?		
3. ¿Cotizaba para una pensión?			7. ¿Tiene pareja en Nicaragua?		
4. ¿Le pagaban sus derechos (aguinaldo etc.)?			8. ¿Tiene hijos en Nicaragua?		

54. En cuanto a los siguientes servicios, ¿a cuáles tenía/tiene usted o su familia acceso…(es decir, hace uso de…)		**A. …en Nicaragua, antes de venir a Costa Rica**		**B. …ahora, en costa Rica?**	
		(1) Sí	**(0) No**	**(1) Sí**	**(0) No**
En la vivienda…	1. Agua potable en la vivienda				
	2. Electricidad				
	3. Teléfono fijo				
	4. Teléfono celular				
	5. Servicio sanitario de inodoro/agua				
	6. Servicio sanitario letrina				
Servicios sociales…	7. Centro de salud				
	8. Hospital				
	9. Escuela para sus hijos				
	10. Colegio para sus hijos				
	11. Guardería				

4c - Sobre por qué vino a Costa Rica

55. ¿Por qué decidió emigrar a otro país, y dejar Nicaragua? *(PEDIR 3 RAZONES, PRIMERO ANOTAR A LA PAR, DESPUÉS LEER ACÁ ABAJO Y LLENAR LOS QUE APLICAN)* →	
1. Necesitaba trabajo y no conseguía en Nicaragua	
2. En otros países pagan mejor por el mismo trabajo	
3. Quería ofrecerle a menores de mi familia mejores condiciones de educación que en Nicaragua	
4. Alguien en su familia necesitaba atención médica que no ofrecen en Nicaragua	
5. Quería tener sus hijos (empezar una familia) en un país con mejores condiciones (educación, salud, ingreso) que Nicaragua	
6. Para estudiar, en el otro país hay mejores centros que en Nicaragua	
7. Motivos familiares (reunir, matrimonio etc.)	
8. Por razones políticas, se tuvo que ir de Nicaragua	
9. Otro, especifique	

Anotar 3 razones que se mencionan….

1. .....

2. .....

3. .....

56. ¿Con quién tomó la decisión de emigrar?	
1. Solo	
2. Junto con su pareja decidieron que usted tenía que ir	
3. Junto con sus padres, hermanos u otros miembros de la familia	
4. Con otra persona	
*Especifique quién*_____	
5. Otro, especifique	

57. ¿Cuándo tomó la decisión de emigrar, consideró otros países además de Costa Rica?		(1) sí	(0) no
Sí, ¿cuáles? (marcar varios si aplican)	1. Estados Unidos		
	2. El Salvador		
	3. Guatemala		
	4. Otro, _____		

58. ¿Por qué decidió venir a Costa Rica, y no otro país (ej. EEUU, El Salvador, Guatemala)? *(marcar los que aplican)*	
1. Tiene familiares/amigos en Costa Rica que le ayudaron	
2. En Costa Rica se consigue trabajo más fácil que en otros países	
3. En Costa Rica, se paga más que en Nicaragua	
4. Costa Rica le queda más cerca que los otros países	
5. Migrar a Costa Rica es menos caro que a los otros países	
6. Además de trabajo, en Costa Rica hay buenos hospitales	
7. Usted/Su pareja estaba embarazada, y sabía que en Costa Rica atienden el parto mejor que en Nicaragua y de manera gratuita	
8. Quería que sus hijos crecieran en Costa Rica, porque tienen acceso a mejores escuelas y colegios.	
9. Intentó emigrar a otro país, pero lo deportaron	
10. Otro, especifique_____	

59. ¿Mencione dos ventajas que tiene Costa Rica sobre otros países para usted? (anotar)

.....

.....

.....

4d - Sobre el cómo de la migración

60. ¿La primera vez que vino a Costa Rica, vino solo/a o acompañado/a? (0) solo (2) acompañado

61. Si 60 = 2: ¿Con quién vino a Costa Rica la primera vez?

1. Con mi pareja
2. Con mis hijos
3. Con mis padres
4. Con amigos/as
5. Con otro familiar, especifique_____
6. Solo

62. ¿Ya conocía a alguien en Costa Rica antes de migrar? (1) sí (0) no

63. ¿Recibió algún tipo de apoyo de alguna persona u organización/institución en Costa Rica? (1) sí (0) no

Sí, ¿de quién? 1. Familiar/amigo 2. ONG/organización 3. Intermediario

Especifique quién o cuál?_____

64. ¿Qué tipo de apoyo le dio/dieron esa(s) persona (s) / entidad(es)?

1. Le dio información
2. Le contactó con alguien que podía ofrecer trabajo
3. Le dio un apoyo financiero
4. Le ayudó con alojamiento
5. Otro, especifique_____

65. Generalmente, ¿cuál es el medio que más utiliza usted para viajar cuando viene desde Nicaragua a Costa Rica?

1. A pie
2. En automóvil
3. En camión/pick up
4. En autobús
5. En avión
6. En lancha
7. En caballo, carreta
8. Otro, especifique_____

66a. ¿Traía documentos cuando ingresó al país? (1) sí (0) no

66b. ¿Con cuáles de los siguientes documentos ingresó usted al país? ¿Cuál mantiene hoy día?	**Antes**	**Ahora**
1. Acta/partida de nacimiento		
2. Acta de bautismo		
3. Cédula o documento de identidad		
4. Pasaporte		
5. Salvoconducto / Permiso especial		
6. Otro, especifique_____		
0. Ninguno		

4e – Sobre el estado migratorio

67. Cuando vino a Costa Rica por primera vez, ¿vino con visa o permiso de trabajo? (1) sí (0) no

Sí, ¿cuál?
1. Visa turística
2. Permiso de trabajo
3. Otro, especifique

68. Cuando vino a Costa Rica la última vez, ¿vino con visa o permiso de trabajo? (1) sí (0) no

Sí, ¿cuál?
1. Visa turística
2. Permiso de trabajo
3. Otro, especifique

69. En este momento, ¿está en el país con su documentación migratoria al día? (¿está "legal"?) (1) sí (0) no

Sí, ¿cuál?
1. Visa turística
2. Permiso de trabajo
3. Residencia temporal
4. Residencia permanente
5. Nacionalidad costarricense
6. Papeles están en trámite
7. No está al día/Irregular
88. No sabe

4f – Sobre las expectativas y la realidad

70. En Costa Rica, ¿fue más fácil o difícil de lo que esperaba antes de migrar de….	1. Más difícil	2. Como lo esperado	3. Más fácil
1. conseguir un trabajo?			
2. conseguir un permiso de trabajo			
3. conseguir un seguro social (CCSS)			
4. conseguir una cita médica?			
5. lograr que sus hijos matriculen en la escuela?			

71. En comparación con Nicaragua, ahora en Costa Rica (1) sí (0) no

1. tiene mayor ingreso?
2. usted o sus hijos tienen (mejor) acceso a la educación?
3. usted o su familia tiene (más) acceso a servicios de salud?
4. usted o su familia tiene (más) acceso a becas y programas especiales del Estado?
5. usted tiene (más) acceso a crédito?
6. usted tiene (más) acceso a bonos de vivienda?

72a. En general, ¿usted siente que para usted y su familia que viven en Costa Rica, ha mejorado la calidad de vida cuando migró? (1) sí (0) no

72b. Si rojo quiere decir que la calidad de vida empeoró mucho, y verde que la calidad de vida mejoró mucho, ¿en cuánto valoraría este cambio? (*5 EMPATA*)

0 1 2 3 4 5 6 7 8 9 10

73a. En general, ¿usted siente que para usted y su familia que vive en Nicaragua, ha mejorado la calidad de vida cuando migró? (1) sí (0) no

73b. Si rojo quiere decir que la calidad de vida empeoró mucho, y verde que la calidad de vida mejoró mucho, ¿en cuánto valoraría este cambio? (*5 EMPATA*)

0 1 2 3 4 5 6 7 8 9 10

74a. ¿Usted quisiera en algún momento regresar a Nicaragua permanentemente? (1) sí (0) no

74b. Si sí, ¿por qué? *Especifique*_____

74c. Y, ¿cuándo? *Especifique*_____

Sección 5 – Sobre las remesas

75. ¿Usted envía alguna ayuda económica en dinero a familiares en Nicaragua? *(NO – PASA A SECCIÓN 6)* (1) sí (0) no

76. ¿Cada cuánto tiempo realiza el envío de dinero?

1. Cada ocho días
2. Cada quince días
3. Una vez al mes
4. Cada dos meses
5. Cada cuatro meses
6. Más, especifique_____
7. Irregular, cuando pueda

77. Las últimas tres veces, en promedio, ¿de cuánto es el monto de esa ayuda económica? *En colones o dólares* ₡ $

78. Y, ¿por cuál medio envía esa ayuda con mayor frecuencia?

1. Familiar/amigo
2. Banco
3. Servicio transporte/buses
4. Encomenderas/personas especiales que llevan dinero
5. Compañía especializada/Remesera, especifique_____
6. Otro, especifique_____

79. ¿Cuántas personas se benefician directamente de la ayuda económica que usted envía? (Anotar)

Cualquier observación adicional

80. ¿Quiénes son las que se benefician directamente?

1. Entrevistado/a
2. Cónyuge/pareja
3. Padre/madre
4. Hijos/hijas
5. Abuelos/as
6. Amigos/as
7. Otro, especifique_____

81. ¿Mencione las tres cosas para que más se usa este dinero que usted envía? *(LEER RESPUESTAS – MARCAR PRIORIDAD con 1,2,3)*

1. Pagar gastos básicos del hogar (comestibles, renta)
2. Ahorro
3. Escuela de los y las hijos e hijas en Nicaragua
4. Pagos préstamos
5. Inversión en negocio
6. Recreación
7. Gastos médicos/medicina
8. Estudios de otra persona
9. Otro, especifique
88. No sabe

82. Y ¿envía usted a su familia artículos o productos que no sean dinero?

1. Ropa
2. Medicinas
3. Comestibles
4. Útiles escolares
5. Computadora o Electrodomésticos
6. Otros, especifique_____
0. No manda

Sección 6- Características socio-económicas

6a - Sobre el trabajo principal

83. En el mes pasado, ¿usted realizó al menos por una hora alguna de las siguientes actividades, recibiendo pago en dinero... *(PREGUNTAR UNO POR UNO)*

1.	participó en labores agropecuarias?	
2.	hizo algo para vender (costuras, manualidades, comida)?	
3.	vendió algún producto (alimentos, joyas, rifas, ventas por catálogo)?	
4.	cuidó niños, ancianos o personas enfermas de otro hogar?	
5.	realizó algún servicio doméstico para personas de otro hogar (limpiar, planchar, etc.)?	
6.	realizó algún servicio de seguridad privada (guachimán, cuidando carros etc.)	
7.	realizó algún trabajo en construcción o reparación de casas o edificios?	
8.	realizó algún otro servicio (como pintar uñas, corte de pelo etc.)?	
9.	realizó trabajos variados, "camarones", "chambas"?	
10.	hizo algún otro trabajo? _____ (especifique que)	
0.	No realizó ninguna	

84. ¿Cuál es su ocupación principal? *(anotar)* _____

85. ¿Ese trabajo que realiza es...	
1. Un negocio, empresa actividad propia, contratando personal permanente?	
2. Un negocio o actividad propia, sin contratar personal o contratando ocasionalmente?	
3. Como empleado para un patrón/empresa/institución privada?	
4. Como empleado para un patrón/empresa/institución del estado?	
5. Como empleado de casas particulares?	
6. Como ayuda a un familiar o conocido sin recibir pago ni en dinero ni en especie?	
7. Un negocio/act. propia, de carácter informal / "camaronea"?	

86. Actualmente, ¿recibe en este trabajo pago en especie?	(1) sí	(0) no
Si sí, ¿de qué tipo?		
87. En ese trabajo, ¿cuántas horas por semana trabaja? *(anotar horas)*		
88. Este trabajo, lo tiene que combinar con cuidar a sus hijos/hijas	(1) sí	(0) no
89. ¿Cuántas horas por semana tiene usted que dedicar exclusivamente al cuidar a sus hijos/hijas		

Trabajo secundario:

90. ¿Además de este, tiene otros trabajos recibiendo pago en dinero o en especie?	(1) sí	(0) no
91. En ese trabajo secundario, ¿cuántas horas por semana trabaja? *(anotar horas)*		

92. ¿Qué hace en este trabajo? *(anotar profesión trabajo secundario)* _____

6b – Sobre las condiciones del trabajo

93. En su trabajo (principal) disfruta de…	(1) sí	(0) no
1. aguinaldo?		
2. días pagos por enfermedad?		
3. vacaciones pagas?		
4. seguro de riesgos de trabajo?		
5. reconocimiento de horas extras?		

95. En este trabajo (principal) tiene rebajas de su salario por…	(1) sí	(0) no
1. seguro social?		
2. impuestos de renta?		
3. rebajas personales que no son de ley/préstamos?		
4. Pensiones alimenticias		

94. ¿En este trabajo cuánto fue su salario el mes pasado, sin ningún tipo de rebaja? *(salario bruto)*

1. Menos de ₡ 50,000 (US$ 100)	
2. Entre ₡50,000 y ₡100,000 (US$100 y 200)	
3. Entre ₡100,000 y ₡150,000 (US$200 y 300)	
4. Entre ₡150,000 y ₡200,000 (US$300 y 400)	
5. Entre ₡200.000 y ₡300,000 (US$400 y 600)	
6. Entre ₡300,000 y ₡400,000 (US$600 y 800)	
7. Más de ₡400,000 (US$800)	

96. ¿Cuánto le rebajaron de su salario en total, el mes pasado, incluidas rebajas de ley y otras que no son de ley? *(CCSS, Bco Popular, impuesto de renta, préstamos, asociaciones, pólizas)*

Anotar monto (o aproximación) en US$/Colones | *US$* | *Colones*

97. ¿Cuánto ganó con su(s) trabajo(s) secundario(s) en el mes pasado?

1. Menos de ₡50,000 (US$100)	
2. Entre ₡50,000 y ₡100,000 (US$100 y 200)	
3. Entre ₡100.000 y ₡250,000 (US$300 y 500)	
4. Más de ₡250,000 (US$500)	

Otros ingresos:

98. Otros ingresos; ¿Usted o alguien en su familia recibe periódicamente ingresos en dinero por concepto de... *[usamos: 1:-año, 2:mes,3: irregular, 4:otro)]*	Sí	No	¿Cuánto recibe?	¿Cada cuánto?
1. alquileres de viviendas, tierras, vehículos, etc.?				
2. intereses de depósitos a plazos, préstamos a terceros y otros?				
3. pensiones del Régimen no Contributivo?				
4. ayudas del IMAS?				
5. otras ayudas estatales o subsidios?				
6. becas?				
7. pensión alimenticia?				
8. pensiones o jubilaciones nacionales (incluye incapacidad permanente)?				
9. pensiones o jubilaciones del extranjero?				
10. aguinaldo de pensión alimenticia, jubilación u otro?				
11. dinero del exterior (remesas)?				
12. dinero de familiares u otras personas en el país?				
13. otras transferencias?				

*6c - Sobre las condiciones de la vivienda. * Observación del encuestador*			
99*. Tipo de vivienda….			
1. Casa en condominio o res. cerrado			
2. Casa independiente			
3. En una fila (pared pega con pared de otra casa)			
4. En edificio (condominio vertical o apartamento)			
5. Cuartería			
6. Tugurio			
7. Otro _____			
100*. ¿Cuál es el estado de...	Malo	Reg	Bueno
1. las paredes exteriores?			
2. el techo?			
3. el piso?			
101. ¿Tiene usted o algún miembro de la familia que vive en esta vivienda…			
1. teléfono celular?			
2. teléfono residencial?			
3. refrigeradora?			
4. sistema de agua caliente para toda la casa?			
5. tanque para almacenar agua?			
6. computadora portátil?			
7. computadora de escritorio?			
8. fax (no de computadora)?			
9. radio o equipo de sonido?			
10. carro (no de trabajo)?			
11. moto (no de trabajo)?			
12. tele de plasma, LCD o LED?			
13. televisor convencional?			
14. router inalámbrico?			
15. televisión pagada (cable, satélite u otro)?			

102. ¿El servicio sanitario es...	
1. Sólo para esta vivienda?	
2. Para esta y otras viviendas?	
0. No tiene	
103. ¿El agua que consumen proviene de ...	
1. Un acueducto del A y A?	
2. Un acueducto rural?	
3. Un acueducto municipal?	
4. Una empresa o cooperativa?	
5. Un pozo?	
6. Un río, quebrada o naciente?	
7. Lluvia u otro?_____	
0. La casa no tiene agua	
104. ¿En esta vivienda hay luz eléctrica...	
1. del ICE?	
2. de la CNFL?	
3. de la ESPH / JASEC?	
4. de una Cooperativa?	
5. de planta privada?	
6. de otra fuente?	
0. No hay luz eléctrica	
105. ¿Esta vivienda, es…	
0. Casa propia totalmente pagada	
1. Casa propia pagando a plazos	
2. Casa alquilada	
3. Casa prestada	
4. Casa en precario (sin derechos formales)	
5. Otra, especifique _____	

106. ¿Cuántos cuartos exclusivos para dormir tiene esta vivienda?	(Anotar no.)

107. <u>Aproximadamente</u>, ¿cuántos metros cuadrados de construcción tiene esta vivienda?	
1. Menos de 30 m^2	
2. De 30 a 40 m^2	
3. De 41 a 60 m^2	
4. De 61 a 100 m^2	
5. De 101 a 150 m^2	
6. De 151 a 200 m^2	
7. Más de 200 m^2	

¡Muchísimas gracias por su colaboración!

Appendix 6. *Migration Characteristics in National Census Data, INEC, 2011.*

Table A6-1. *Selected Variables for Migration Characteristics of Nicaraguan Born Population in National Census, 2011.*

Variable	*Nicaragua*
Mean Age (in years)	32.62
Mean Age (over 15 years old, in years)	35.88
Age Distribution in % (N= 287,766)	
Below 15	9.0
15-24	21.2
25-34	27.9
35-44	21.1
45-54	11.0
55-64	5.3
65-74	2.5
75 and Over	2.0
Average Formal Education in Years	6.34
Average Household Size	4.60
Average Number of Children Per Woman	2.63
Marital Status in % (N=285,409)	
Cohabitation	5.7
Married	36.9
Separated	22.8
Divorced	3.8
Widowed	1.2
Single	2.0
% Performed Paid Work (N=285,409)	53.85
Economically Active Population (EAP) (N=271,427)	51.40
Period of Arrival % (N= 287,766)	
Before 1970	1.6
1970 to 1979	2.4
1980 to 1989	5.4
1990 to 1999	19.4
2000 to 2009	20.5
2010 to 2019	4.4

Source: Own elaboration based on INEC (2011).

Appendix 7. *Access to Public Healthcare and Medicine by Area of Residence*

Table A7-1. *Access to Public Healthcare and Medicine by Country of Birth and Area of Residence, 2013. (Percentages)*

	Costa Rica			*Nicaragua*		
Variable	*Total*	*Urban*	*Rural*	*Total*	*Urban*	*Rural*
N	401	281	120	394	272	122
HEALTHCARE						
CCSS Free Public Healthcare	78.8	79.0	78.3	58.1	57.4	59.8
No CCSS Free Public Healthcare	21.2	21.0	21.7	41.9	42.6	40.2
CCSS Paid Healthcare	1.5	1.4	1.7	5.8	7.4	2.5
Will Not be Attended	2.0	1.1	4.2	18.5	16.5	23.0
Preference for Private Healthcare	7.0	8.9	2.5	4.1	4.8	2.5
Other Reason	4.5	4.6	4.2	6.9	7.0	6.6
Unknown Reason	6.2	5.0	9.2	6.6	7.0	5.7
MEDICINE						
CCSS Free Medicine	69.8	66.9	76.7	47.5	43.0	57.4
Combination: CCSS and Private	2.5	3.2	0.8	3.8	4.4	2.5
Private Medicine	25.7	28.1	20.0	45.4	51.1	32.8
Pharmacy, Paid	24.9	27.0	20.0	43.7	49.3	31.1
CCSS, Paid	0.2	0.4	0.0	0.3	0.4	0.0
Contact, Paid	0.5	0.7	0.0	0.8	0.4	1.6
From Nicaragua, Paid	0.0	0.0	0.0	0.8	1.1	0.0
Other	2.0	1.8	2.5	3.3	1.5	7.4
Total	**100**	**100**	**100**	**100**	**100**	**100**

SOURCE: Own elaboration based on MISOC survey (2013).

Table A7-1. *Access to Public Healthcare for Children (under 18) by Country of Birth and Area of Residence, 2013. (Percentages)*

	Costa Rica			*Nicaragua*		
Variable	*Total*	*Urban*	*Rural*	*Total*	*Urban*	*Rural*
N	227	150	77	296	197	99
HEALTHCARE						
CCSS Free Public Healthcare	79.3	80.0	77.9	80.1	79.7	80.8
No CCSS Free Public Healthcare	11.5	13.3	7.8	13.2	13.7	12.1
CCSS Paid Healthcare	0.0	0.0	0.0	1.0	1.0	1.0
Will Not be Attended	0.0	0.0	0.0	4.1	4.1	4.0
Preference for Private Healthcare	0.4	0.7	0.0	0.3	0.0	1.0
Other Reason	9.3	11.3	5.2	5.1	5.6	4.0
Unknown Reason	1.8	1.3	2.6	2.7	3.0	2.0
Unknown	9.3	6.7	14.3	6.8	6.6	7.1
MEDICINE						
CCSS Free Medicine	65.6	64.0	68.8	63.9	58.9	73.7
Combination: CCSS and Private	1.3	1.3	1.3	2.0	2.0	2.0
Private Medicine	19.8	24.7	13.0	24.7	29.9	15.2
Pharmacy, Paid	18.5	22.0	11.7	22.6	26.9	14.1
CCSS, Paid	0.9	0.7	1.3	1.0	1.5	0.0
Contact, Paid	0.4	0.7	0.0	0.3	0.0	1.0
From Nicaragua, Paid	0.0	0.0	0.0	0.7	1.0	0.0
Other	0.9	1.3	0.0	0.3	0.5	0.0
Total	**100**	**100**	**100**	**100**	**100**	**100**

SOURCE: Own elaboration based on MISOC survey (2013).

Appendix 8. *Means Tests for Selected Variables*

Table A8-1. *Means T-test for selected Variables by Country of Birth, and Legal Status, 2013.*

	Means Test	*Costa Rica*	*Nicaragua*	*Denizen*	*'Illegal'*	*Diff. CR-NIC*	*Diff. CR-Denizen*	*Diff. Denizen-'Illegal'*
Demographic Char.	Age Interviewee	45.85	39.78	42.13	35.87	6.074***	3.724**	6.254***
	Years Education Interviewee	6.11	5.33	5.26	5.45	0.772**	0.845**	-0.193
Household Char.	Sex HH Head	0.43	0.40	0.43	0.34	0.0305	-0.00603	0.0971
	Age HH Head	50.39	41.76	43.51	38.84	8.663***	6.877***	4.674***
	Children under 6 Years Old	0.27	0.40	0.39	0.43	-0.137***	-0.123***	-0.0354
	Children from 7 to 18 Years Old	0.30	0.35	0.37	0.31	-0.049	-0.0707	0.0591
	Children under 18 Years Old	0.57	0.75	0.76	0.74	-0.185***	-0.194***	0.0237
	Household Type							
	Traditional	0.35	0.45	0.42	0.49	-0.0951**	-0.0686	-0.0705
	Modified	0.14	0.26	0.28	0.23	-0.119***	-0.137***	0.0467
	Single	0.27	0.20	0.21	0.18	0.0763*	0.067	0.0249
	Other	0.23	0.09	0.09	0.09	0.138***	0.138***	-0.0011
Health Services	Health Insurance	0.85	0.64	0.87	0.24	0.218***	-0.0171	0.627***
	Salaried Workers	0.19	0.19	0.25	0.09	0.002	-0.0584	0.160***
	Independent Workers & Voluntary	0.11	0.11	0.16	0.02	0.003	-0.0504	0.142***
	Family Insurance	0.32	0.24	0.35	0.06	0.0806*	-0.0279	0.289***
	Insurance by the State	0.08	0.03	0.03	0.01	0.0494**	0.0423	0.019
	RNC & IVM Pensioners	0.13	0.02	0.03	0.01	0.109***	0.104***	0.0149
	Other	0.01	0.01	0.00	0.01	0.0049	0.00591	-0.00269

	Means Test	*Costa Rica*	*Nicaragua*	*Denizen*	*'Illegal'*	*Diff. CR-NIC*	*Diff. CR-Denizen*	*Diff. Denizen-'Illegal'*
Health Services	CCSS Free Public Healthcare	0.79	0.58	0.77	0.26	0.207***	0.0157	0.509***
	CCSS Free Pub. Health. for Child. (u18)	0.45	0.60	0.63	0.56	-0.153***	-0.177***	0.0652
	CCSS Free Medicine	0.70	0.48	0.65	0.18	0.224***	0.0478	0.468***
	Private Medicine	0.26	0.45	0.28	0.75	-0.197***	-0.0196	-0.474***
	CCSS Free Meds for Children (u18)	0.37	0.48	0.49	0.47	-0.108**	-0.116**	0.0216
	Private Medicine for Children (u18)	0.11	0.19	0.17	0.22	-0.0731**	-0.0544*	-0.0495
Labour Market	Income Category Interviewee	1.61	2.14	2.35	1.78	-0.531**	-0.748***	0.577*
	Main Occupation							
	Professor & Technician	0.12	0.07	0.07	0.07	0.0512*	0.0547*	-0.00928
	Paid Domestic Work	0.02	0.12	0.13	0.11	-0.099***	-0.108***	0.022
	Daily Pawn Labours	0.03	0.14	0.14	0.14	-0.110***	-0.112***	0.00714
	Salesperson	0.10	0.11	0.13	0.06	-0.0118	-0.0394	0.0733*
	Farmers and Fishermen	0.01	0.02	0.02	0.01	-0.00276	-0.00379	0.00275
	Security	0.01	0.02	0.02	0.02	-0.0053	-0.00379	-0.00401
	Other	0.21	0.11	0.12	0.10	0.0953***	0.0891**	0.0165
	Number of Hours per Week	39.93	44.72	45.07	44.04	-4.789*	-5.135*	1.032
	Second Job	0.16	0.20	0.19	0.21	-0.0352	-0.0279	-0.0185
	Labour Rights							
	13th Month	0.22	0.32	0.38	0.21	-0.0953**	-0.159***	0.169***
	Sick Days	0.19	0.23	0.28	0.14	-0.0364	-0.0885**	0.139**
	Paid Holidays	0.20	0.28	0.34	0.18	-0.0722*	-0.133***	0.162***
	Risk Insurance	0.19	0.19	0.25	0.10	-0.00835	-0.0634	0.147***
	Paid Extra Hours	0.14	0.22	0.26	0.16	-0.0837**	-0.119***	0.0939*

	Means Test	*Costa Rica*	*Nicaragua*	*Denizen*	*'Illegal'*	*Diff. CR-NIC*	*Diff. CR-Denizen*	*Diff. Denizen-'Illegal'*
Migration	In Nicaragua, Access to:							
	Social Security			0.16	0.22			-0.0606
	Paid Work			0.41	0.51			-0.0947
	Hospital/Healthcare			0.89	0.91			-0.0181
	Migration Process							
	Migrated accompanied			0.61	0.53			0.076
	Support in CR			0.78	0.77			0.0031
	Brought legal documents to CR			0.72	0.75			-0.0277
	CR contact before migrating			0.68	0.77			-0.0882
	In Costa Rica							
	Time in Costa Rica			21.90	14.79			7.112***
	Send remittances			0.47	0.53			-0.0669
	Amount last remittance in US $			118.89	125.16			-6.275
	No. Of beneficiaries			1.91	2.32			-0.413
Obs.						795	647	394

Source: Own elaboration based on MISOC survey (2013).

Appendix 9. *Regression Results to Chapter 8*

Table A9-1. *Probit Regression Results for Insurance (I).*
(Marginal Effects Reported)

			Dependent Variable: Access to Public Health Insurance (I)						
		Model:	*(1)*	*(2)*	*(3)*	*(1a)*	*(1b)*	*(2)*	*(3)*
		Population:	*Nicaragua Only*			*Entire Population*			
		Regression #	(1)	(2)	(3)	(4)	(5)	(6)	(7)
D	Age 2		-0.000*	-0.000	0.000	-0.000	-0.000	-0.000	-0.000
			(0.000)	*(0.000)*	*(0.000)*	*(0.000)*	*(0.000)*	*(0.000)*	*(0.000)*
HH	Children from 7 to 18 y/o		-0.106	-0.139	-0.136	0.028	0.007	0.004	0.013
			(0.089)	*(0.095)*	*(0.096)*	*(0.038)*	*(0.041)*	*(0.040)*	*(0.039)*
	Costa Rican Adult		-0.017	0.020	0.040				
			(0.100)	*(0.110)*	*(0.107)*				
	Traditional HH		0.002			0.044	0.039		
			(0.067)			*(0.033)*	*(0.034)*		
	Modified HH			0.005	0.011			-0.022	-0.022
				(0.092)	*(0.093)*			*(0.053)*	*(0.056)*
	Single HH			-0.011	0.043			-0.083+	-0.057
				(0.093)	*(0.092)*			*(0.049)*	*(0.050)*
	Other HH			0.056	0.084			-0.032	-0.004
				(0.109)	*(0.106)*			*(0.061)*	*(0.059)*
	HH Head		0.037	-0.009	0.049	-0.000	-0.007	-0.016	-0.013
			(0.070)	*(0.071)*	*(0.085)*	*(0.037)*	*(0.038)*	*(0.037)*	*(0.039)*

		Dependent Variable: Access to Public Health Insurance (I)						
	Model:	*(1)*	*(2)*	*(3)*	*(1a)*	*(1b)*	*(2)*	*(3)*
	Population:	*Nicaragua Only*			*Entire Population*			
	Regression #	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
LM	Professor & Technician		0.074	-0.153			-0.012	-0.116
			(0.144)	*(0.230)*			*(0.091)*	*(0.125)*
	Paid Domestic Work		-0.062	0.000			-0.046	-0.016
			(0.122)	*(0.140)*			*(0.080)*	*(0.078)*
	Daily Pawn Labours		-0.132	-0.239			-0.111	-0.198
			(0.147)	*(0.166)*			*(0.114)*	*(0.128)*
	Salesperson		-0.102	-0.110			-0.062	-0.044
			(0.147)	*(0.166)*			*(0.075)*	*(0.078)*
	Farmers and Fishermen		0.021	0.106			-0.036	0.065
			(0.268)	*(0.224)*			*(0.167)*	*(0.122)*
	Security		-0.249	-0.42+			-0.070	-0.118
			(0.217)	*(0.242)*			*(0.137)*	*(0.159)*
	Other		0.026	0.017				
			(0.112)	*(0.120)*				
	Other Services						-0.053	-0.029
							(0.070)	*(0.070)*
	Pensioners						0.128*	0.154***
							(0.055)	*(0.045)*
	HHH Professor & Technician			0.198*				0.068
				(0.092)				*(0.051)*
	HHH Paid Domestic Work			-0.139				-0.144
				(0.163)				(0.109)

		Dependent Variable: Access to Public Health Insurance (I)						
	Model:	*(1)*	*(2)*	*(3)*	*(1a)*	*(1b)*	*(2)*	*(3)*
	Population:	*Nicaragua Only*			*Entire Population*			
	Regression #	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
LM	HHH Daily Pawn Labours			*0.069*				*0.037*
				(0.100)				(0.052)
	HHH Salesperson			*-0.056*				*-0.098*
				(0.151)				*(0.089)*
	HHH Farmers & Fishermen			*-0.167*				*-0.181*
				(0.202)				*(0.145)*
	HHH Security			*0.109*				*-0.031*
				(0.128)				*(0.093)*
	HHH Other			*-0.116*				
				(0.111)				
	HHH Other Services							*-0.169**
								(0.077)
	HHH Pensioners							*-0.126*
								(0.118)
Observations		394	394	394	795	795	795	795
Pseudo R2		0.310	0.442	0.460	0.221	0.271	0.357	0.375

*Robust standard errors in parentheses: ***p<0.001, **p<0.01, *p<0.05, + p<0.1*

Source: Own elaboration.

Table A9-2. *Probit Regression Results for Healthcare (H). (Marginal Effects Reported)*

		Dependent Variable: Access to Public Healthcare (H)							
	Model:	*(1)*	*(2)*	*(3)*	*(4)*	*(1)*	*(2)*	*(3)*	*(4)*
	Population:	*Nicaragua Only*				*Entire Population*			
	Regression #	**(8)**	**(9)**	**(10)**	**(11)**	**(12)**	**(13)**	**(14)**	**(15)**
D	Age 2	-0.000	0.000	0.000	0.000	-0.000	-0.000	-0.000	-0.000
		(0.000)	*(0.000)*	*(0.000)*	*(0.000)*	*(0.000)*	*(0.000)*	*(0.000)*	*(0.000)*
HH	Children 7-18 y/o	0.035	0.039	0.052	0.098	0.034	0.025	0.028	0.033
		(0.078)	*(0.083)*	*(0.083)*	*(0.089)*	*(0.045)*	*(0.046)*	*(0.046)*	*(0.048)*
	Costa Rican Adult		-0.086	-0.095	-0.137				
			(0.098)	*(0.099)*	*(0.117)*				
	Traditional HH	-0.004				0.016			
		(0.068)				*(0.040)*			
	Modified HH		-0.059	-0.096	-0.132		-0.059	-0.056	-0.054
			(0.090)	*(0.093)*	*(0.104)*		*(0.057)*	*(0.059)*	*(0.062)*
	Single HH		0.043	-0.003	-0.023		-0.069	-0.078	-0.055
			(0.087)	*(0.095)*	*(0.103)*		*(0.053)*	*(0.056)*	*(0.057)*
	Other HH		0.135	0.093	0.091		0.092	*0.096*	*0.120**
			(0.101)	*(0.111)*	*(0.123)*		*(0.057)*	*(0.062)*	*(0.059)*
	HH Head	0.030	-0.040	-0.111	-0.169+	-0.008	-0.028	-0.052	-0.058
		(0.070)	*(0.076)*	*(0.085)*	*(0.089)*	*(0.044)*	*(0.045)*	*(0.049)*	*(0.054)*
LM	Prof. & Techn.		0.111	0.133	0.200		-0.150	-0.128	-0.084
			(0.146)	*(0.163)*	*(0.150)*		*(0.103)*	*(0.111)*	*(0.117)*
	Paid Domestic Work		0.049	-0.001	-0.005		0.023	0.005	-0.005
			(0.117)	(0.153)	(0.163)		(0.084)	(0.101)	(0.106)

		Dependent Variable: Access to Public Healthcare (H)							
	Model:	*(1)*	*(2)*	*(3)*	*(4)*	*(1)*	*(2)*	*(3)*	*(4)*
	Population:	*Nicaragua Only*				*Entire Population*			
	Regression #	**(8)**	**(9)**	**(10)**	**(11)**	**(12)**	**(13)**	**(14)**	**(15)**
LM	Daily Pawn Labours		-0.046	0.012	0.129		0.026	0.006	0.075
			(0.149)	*(0.163)*	*(0.172)*		*(0.096)*	*(0.105)*	*(0.098)*
	Salesperson		-0.038	0.055	0.140		-0.043	-0.014	-0.003
			(0.132)	*(0.143)*	*(0.136)*		*(0.078)*	*(0.084)*	*(0.086)*
	Farmers & Fishermen		0.213	0.371***	0.379***		0.221*	0.284***	0.273***
			(0.231)	*(0.083)*	*(0.077)*		*(0.098)*	*(0.031)*	*(0.027)*
	Security		-0.376+	-0.256	-0.173		-0.308+	-0.268	-0.275
			(0.197)	*(0.257)*	*(0.271)*		*(0.170)*	*(0.188)*	*(0.196)*
	Other		-0.108	-0.032	-0.049				
			(0.121)	*(0.128)*	*(0.138)*				
	Other Services						-0.104	-0.094	-0.117
							(0.084)	*(0.084)*	*(0.095)*
	Pensioners						-0.030	0.077	0.004
							(0.105)	*(0.105)*	*(0.127)*
	HH Prof. & Techn.			-0.136	-0.270*			-0.060	-0.114
				(0.123)	*(0.129)*			*(0.070)*	*(0.076)*
	HH Paid Domestic Work			-0.009	0.064			-0.020	0.047
				(0.155)	*(0.157)*			*(0.108)*	*(0.096)*
	HH Daily Pawn Labours			-0.183	-0.255*			-0.000	-0.019
				(0.115)	*(0.127)*			*(0.069)*	*(0.075)*
	HH Salesperson			-0.256+	-0.289+			-0.108	-0.080
				(0.152)	*(0.172)*			*(0.095)*	*(0.104)*
	HH Farmers & Fishermen			-0.435***	-0.471***			-0.354*	-0.341*
				(0.128)	*(0.121)*			*(0.147)*	*(0.160)*

		Dependent Variable: Access to Public Healthcare (H)							
	Model:	*(1)*	*(2)*	*(3)*	*(4)*	*(1)*	*(2)*	*(3)*	*(4)*
	Population:	*Nicaragua Only*				*Entire Population*			
	Regression #	**(8)**	**(9)**	**(10)**	**(11)**	**(12)**	**(13)**	**(14)**	**(15)**
LM	HH Security			-0.333*	-0.435***			-0.152	-0.160
				(0.150)	*(0.123)*			*(0.117)*	*(0.128)*
	HH Other			-0.222*	-0.228+				
				(0.108)	*(0.123)*				
	HH Other Services							-0.059	0.008
								(0.072)	*(0.075)*
	HH Pensioners							-0.159	-0.132
								(0.120)	*(0.128)*
Observations		394	394	394	394	795	795	795	795
Pseudo R2		0.150	0.254	0.273	0.381	0.135	0.200	0.209	0.325

*Robust standard errors in parentheses: *** p<0.001, ** p<0.01, * p<0.05, + p<0.1*

SOURCE: Own elaboration.

Table A9-3. *Probit Regression Results for Medicine (M). (Marginal Effects Reported)*

		Dependent Variable: Access to Public Medicine (M)							
	Model:	*(1)*	*(2)*	*(3)*	*(4)*	*(1)*	*(2)*	*(3)*	*(4)*
	Population:	*Nicaragua Only*				*Entire Population*			
	Regression #	**(16)**	**(17)**	**(18)**	**(19)**	**(20)**	**(21)**	**(22)**	**(23)**
D	Age	0.008	-0.021	-0.024	-0.035*	0.003	-0.002	-0.002	-0.009
		(0.012)	*(0.015)*	*(0.015)*	*(0.014)*	*(0.007)*	*(0.008)*	*(0.008)*	*(0.009)*
	Sex	0.087	0.109	0.095	0.148	0.001	-0.022	-0.026	0.043
		(0.080)	*(0.100)*	*(0.101)*	*(0.108)*	*(0.049)*	*(0.058)*	*(0.059)*	*(0.063)*
M	Years in Costa Rica	0.008*	0.001	0.002	0.002	0.006***	0.001	0.002	0.002
		(0.003)	*(0.004)*	*(0.004)*	*(0.004)*	*(0.002)*	*(0.002)*	*(0.002)*	*(0.002)*
	Costa Rican Contact	0.009	0.017	0.011	0.013	0.006	0.030	0.032	0.028
		(0.061)	*(0.065)*	*(0.067)*	*(0.069)*	*(0.054)*	*(0.062)*	*(0.062)*	*(0.064)*
	Illegal	-0.340***	-0.506***	-0.506***	-0.335***	-0.349***	-0.426***	-0.419***	-0.202*
		(0.057)	*(0.066)*	*(0.065)*	*(0.098)*	*(0.063)*	*(0.070)*	*(0.071)*	*(0.097)*
	Nationalized						0.045	0.054	-0.003
							(0.105)	*(0.104)*	*(0.109)*
	Residency		-0.079	-0.079	-0.065		0.018	*0.032*	*0.008*
			(0.111)	*(0.111)*	*(0.109)*		*(0.072)*	*(0.072)*	*(0.077)*
	Tourist		-0.472***	-0.476***	-0.305**		-0.462***	-0.466***	-0.215
			(0.053)	*(0.050)*	*(0.110)*		*(0.087)*	*(0.086)*	*(0.141)*
	In Process		*-0.488****	*-0.496****	*-0.431****		*-0.492****	*-0.491****	*-0.397****
			(0.047)	(0.044)	(0.063)		(0.073)	(0.073)	(0.109)
			(0.146)	*(0.163)*	*(0.150)*		*(0.103)*	*(0.111)*	*(0.117)*
LM	Insurance				0.539***				0.576***
					(0.063)				*(0.043)*
	13th Month	-0.259+	-0.317*	-0.327*	-0.371*	-0.149	-0.138	-0.143	-0.137
		(0.137)	*(0.141)*	*(0.148)*	*(0.145)*	*(0.107)*	*(0.116)*	*(0.120)*	*(0.129)*

		Dependent Variable: Access to Public Medicine (M)							
	Model:	*(1)*	*(2)*	*(3)*	*(4)*	*(1)*	*(2)*	*(3)*	*(4)*
	Population:	*Nicaragua Only*				*Entire Population*			
	Regression #	**(16)**	**(17)**	**(18)**	**(19)**	**(20)**	**(21)**	**(22)**	**(23)**
LM	Sick Days	-0.194+	-0.203+	-0.201+	-0.126	-0.101	-0.103	-0.099	-0.074
		(0.108)	*(0.114)*	*(0.121)*	*(0.128)*	*(0.090)*	*(0.092)*	*(0.093)*	*(0.098)*
	Paid Holidays	0.267+	0.238	0.218	0.210	0.223*	0.204+	0.221*	0.203+
		(0.140)	*(0.157)*	*(0.169)*	*(0.176)*	*(0.095)*	*(0.105)*	*(0.105)*	*(0.113)*
	Risk Insurance	0.327**	0.287*	0.317*	0.082	0.170*	0.161+	0.152+	-0.009
		(0.100)	*(0.127)*	*(0.131)*	*(0.147)*	*(0.073)*	*(0.083)*	*(0.085)*	*(0.096)*
	Paid Overtime	-0.068	-0.069	-0.063	0.063	-0.051	-0.056	-0.071	-0.045
		(0.107)	*(0.112)*	*(0.114)*	*(0.124)*	*(0.076)*	*(0.079)*	*(0.081)*	*(0.091)*
	Education	-0.001	-0.000	-0.001	-0.001	-0.001	-0.002	-0.001	-0.001
		(0.008)	*(0.008)*	*(0.008)*	*(0.009)*	*(0.006)*	*(0.006)*	*(0.006)*	*(0.006)*
	Income Category	-0.011	-0.001	0.002	-0.007	-0.025*	-0.018	-0.017	-0.029+
		(0.018)	*(0.023)*	*(0.024)*	*(0.025)*	*(0.011)*	*(0.014)*	*(0.014)*	*(0.015)*
HH	Children under 6 y/o	0.022	0.012	0.020	0.113	0.100*	0.115*	0.108*	0.143*
		(0.078)	*(0.091)*	*(0.090)*	*(0.094)*	*(0.051)*	*(0.052)*	*(0.053)*	*(0.056)*
	Costa Rican Child		0.132	0.140	0.079				
			(0.107)	*(0.108)*	*(0.113)*				
C	Urban Area	-0.143*	-0.089	-0.087	-0.123	-0.135***	-0.088*	-0.083+	-0.106*
		(0.062)	*(0.071)*	*(0.073)*	*(0.076)*	*(0.040)*	*(0.043)*	*(0.045)*	*(0.047)*
	Housing Quality	0.025**	0.023*	0.028**	0.023*	0.009	0.007	0.007	0.004
		(0.010)	*(0.010)*	*(0.011)*	*(0.012)*	*(0.006)*	*(0.007)*	*(0.007)*	*(0.007)*
	Observations	394	394	394	394	795	795	795	795
	Pseudo R2	*0.155*	*0.266*	*0.286*	*0.385*	*0.147*	*0.200*	*0.210*	*0.323*
	Log likelihood	-230.42	-200.12	-194.58	-167.67	-459.49	-430.85	-425.64	-364.80

*Robust standard errors in parentheses: ***p<0.001, **p<0.01, *p<0.05, + p<0.1. SOURCE: Own elaboration.*

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